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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

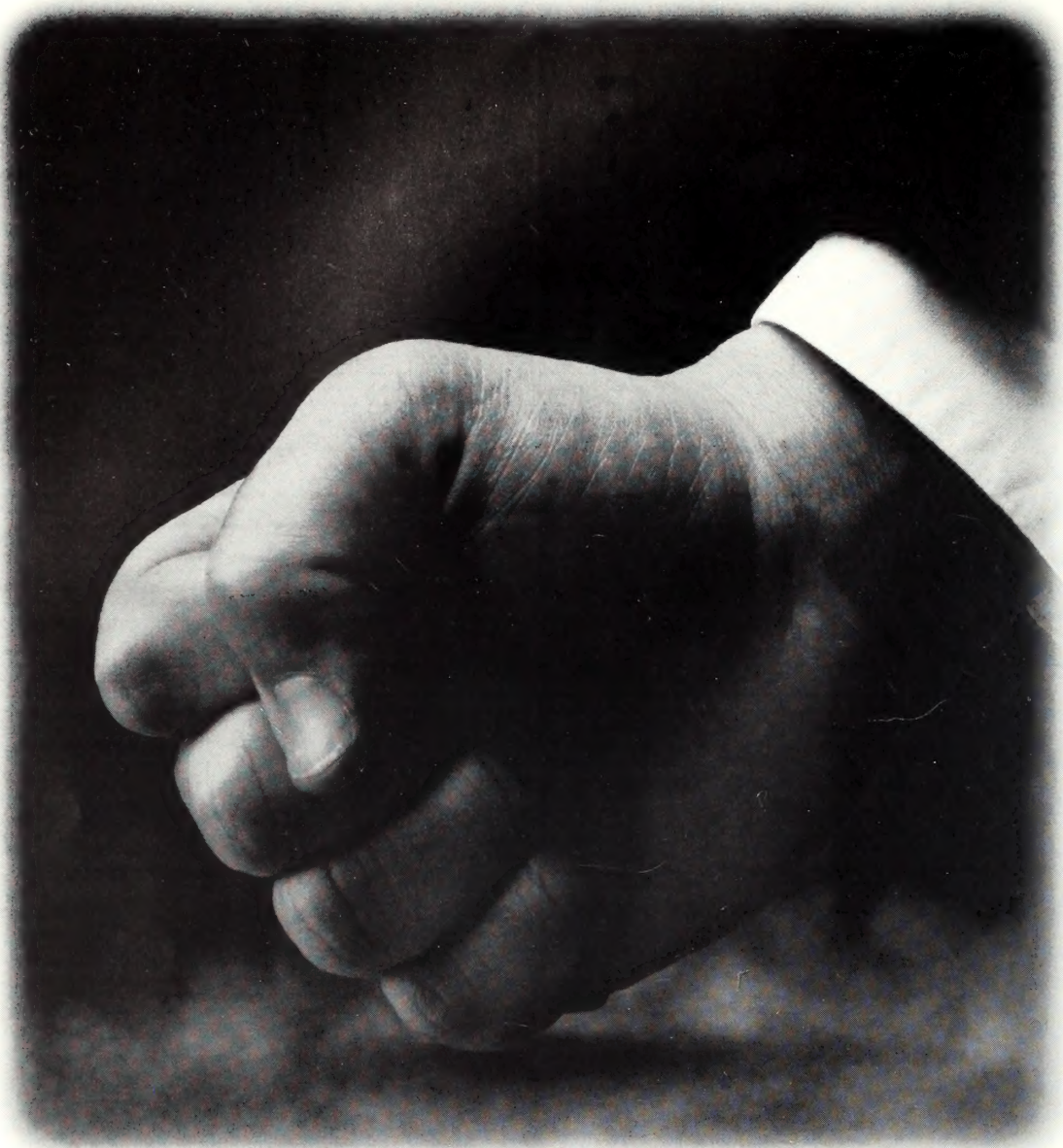
January/February 1995

Vol. 88, No. 1



**Under the Statehouse dome:  
ISMA pursues full agenda**





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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

January/February 1995 Vol. 88, No. 1

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features JAN 18 1995

## Physician explains PO, PHO formation ..... 8

*Indiana Medicine* interviews Alan Snell, M.D., who shares his hands-on experience in building successful POs, PHOs, HMOs and PPOs in northern Indiana.

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The November elections dramatically changed the political landscape. How this change will affect the many bills that ISMA physicians want passed is unclear, but one thing is certain - grassroots support is often the key to victory.

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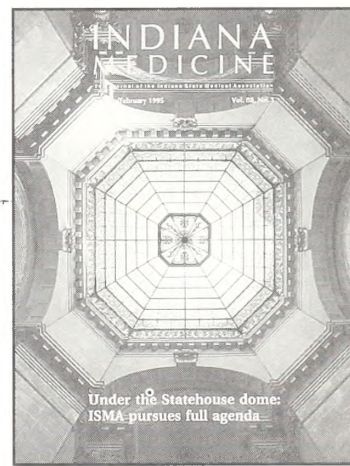
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Cover photo by Garry Chilluffo of Indianapolis shows view of stained glass dome above the Indiana Statehouse rotunda.

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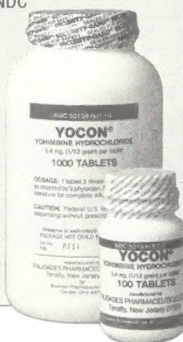
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#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## **ISMA schedules workshop for medical society officers**

The ISMA will sponsor Leadership '95, a half-day workshop for officers of county and district medical societies, the Resident Medical Society and the Student Medical Society. The event will be held Saturday, Feb. 25, from 8:30 a.m. to 1:30 p.m. at the Ruth Lilly Center for Health Education, 2055 N. Senate Ave., Indianapolis.

Speakers and their topics will include: Michael Abrams, ISMA director of government relations, "It's Not Politics as Usual: The Brave New World of Republican Majorities in the Congress and the Indiana General Assembly"; John D. MacDougall, M.D., IMPAC chairman, "PAC Man Cometh"; Tim Brent, ISMA marketing department, "The State of the ISMA: ISMA Strategic Health," "Members, Mentors: Recruiting for the Future" and "POMC, Physician Office Management Consulting"; Barbara Walker, ISMA practice management coordinator, "Practice (Management) Makes Perfect: A Look at the 1995 ISMA Workshops"; and Alan Snell, M.D., Michiana HealthNet medical director, "Community Planning."

For more information, call Adele Lash at the ISMA, (317) 261-2060 or 1-800-257-4762.

## **ISMA offers workshops on documentation guidelines**

The Health Care Financing Administration has released new *Documentation Guidelines for Evaluation and Management (E&M) Services*. To help physicians and their staffs increase their comprehension and ability to communicate internally and with the carrier through proper code billings, the ISMA is conducting workshops with Joseph Caldwell, M.D., Medicare medical director. Half-day workshops will be presented on the following dates and locations: Jan. 18, Floyd Memorial Hospital, New Albany; Jan. 25, Deaconess Hospital, Evansville; Feb. 1, St. Joseph Medical Center, Fort Wayne; and Feb. 8, Broadway Methodist Hospital, Merrillville.

The E&M service codes and payments were initially introduced in 1992, but the new guidelines provide a method of validation of history assessment and complexity, physician exam completeness and decision making complexity, thereby providing a basis for medical review to confirm proper code billing for E&M services. For more information, call the ISMA, (317) 261-2060 or 1-800-257-4762.

## **ISMA invites physicians to meet with legislators Jan. 25**

ISMA Key Contact physicians will meet with state legislators to discuss issues of concern during the ISMA's annual Medicine Day, Jan. 25, at the Hyatt Regency Hotel in downtown Indianapolis.

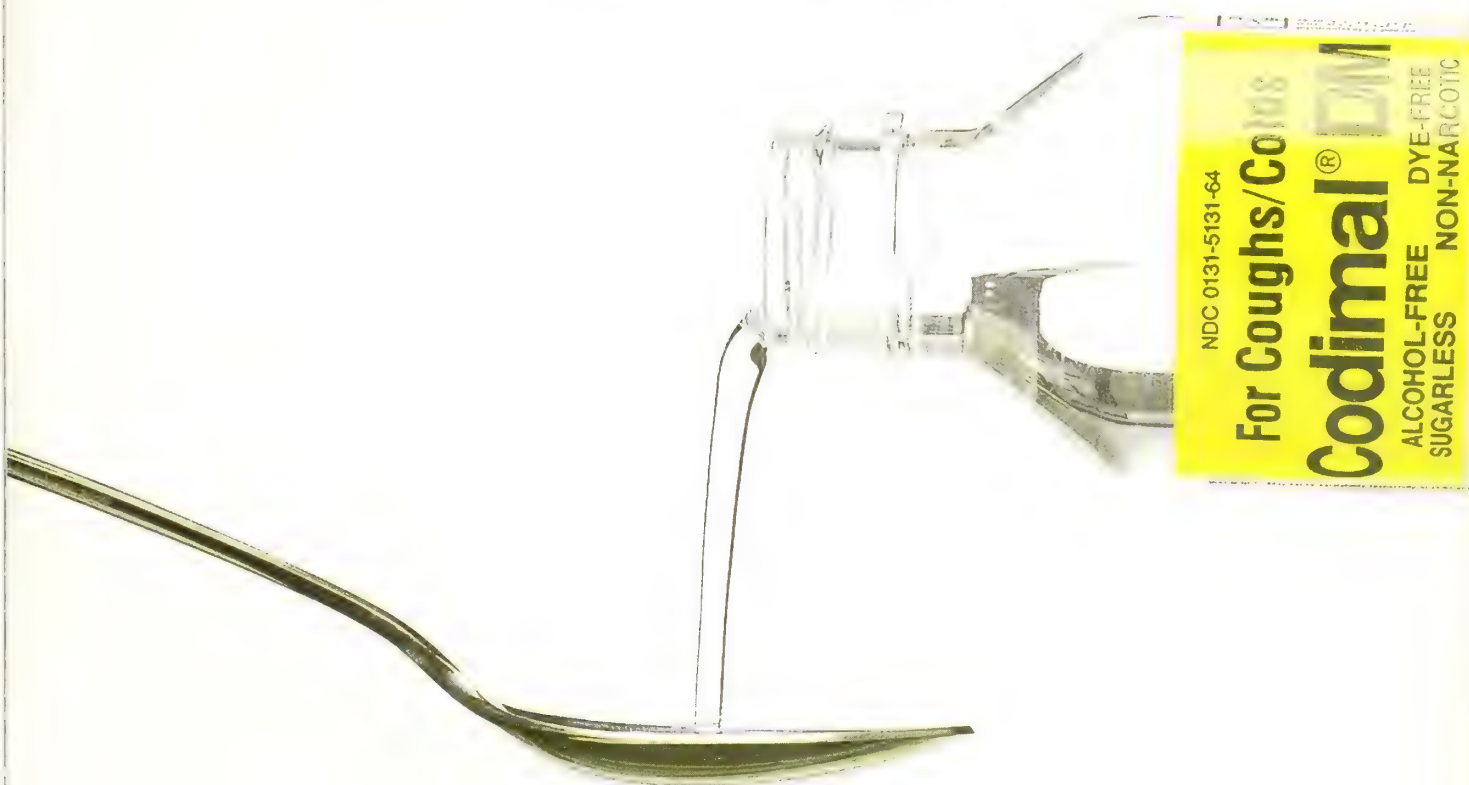
The day includes a breakfast briefing on legislative issues, a visit to the Statehouse to meet with legislators and a luncheon to which all legislators are invited. The day will conclude with the ISMA/IMPAC Legislative Reception from 6 p.m. to 8:30 p.m. at the Hyatt Regency.

For information, call the ISMA, (317) 261-2060 or 1-800-257-4762. □



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## ■ letter to editor

### Physician calls for vigilance on health system reform

**A**nd the bad news is: Health care reform is not dead. Hillary Clinton blames bad politics for the failure of a health care reform bill to make it to a vote before the recess. The latest announcement from the administration is that it will be back in 1995 but with the political error corrected: Mrs. Clinton and Ira Magaziner will remain in the background like puppeteers, pulling the strings – but you won't see them.

Mrs. Clinton added that people in this country had been trying for decades to get government-run, universally mandated health care through the Congress.

In her mania for power,

Clinton does not recognize that since Wilbur Cohen first tried to socialize the entire provision of medical care in America since the mid-1930s, hundreds of millions of Americans have repeatedly fought to stave off the efforts of a few dozen members of the Congress, a few presidents and various other "liberals," both within and outside of the political structure, who actively seek a politically dominated, government controlled, semi-European style of socialized medicine. Who in his right mind wants it? One more time we Americans have managed to convince a majority of members of the 103rd Congress that we did not even trust a vote on the matter, lest something get slipped off on us as

has so often happened before.

With health care reform going underground, the need for citizen vigilance is greater than ever. Just as three-fourths of Medicare/Medicaid legislation has been slipped through as riders on other bills, we can expect to find next year's health care reform bills tacked piecemeal onto bills such as those concerning public lands, banking, wetlands conservation, etc.

We're going to get it folks. We're just not going to see it coming unless we go after the 104th Congress right away. □

**George C. Manning, M.D.**  
Fort Wayne

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# Doctor explains

Bob Carlson  
Indianapolis

**P**artners Health Plan of Indiana, the state's third-largest HMO, will celebrate its 10th anniversary in 1996. What makes its success all the sweeter is that it's a homegrown product in a state where for many years managed care was something that happened mostly elsewhere.

Headquartered in South Bend, Partners was the community's first provider-owned managed care plan. Partners has grown to more than 70 employees and 700 physicians who provide health care to 50,000 Hoosiers in South Bend, Elkhart and Fort Wayne.

For an inside look at the making of Partners Health Plan of Indiana, *Indiana Medicine* talked with Alan Snell, M.D., who helped start the HMO and served as its first medical director. He also has served as president of Michiana Medical Associates, the physician organization (PO) that, together with Memorial Hospital in South Bend, created the HMO. Under Dr. Snell's leadership, Michiana Medical Associates formed another physician hospital organization (PHO) with Memorial Hospital in 1991 to create Michiana HealthNet, a preferred provider organization (PPO).

A native of Brazil, Ind., Dr. Snell graduated from the Indiana University School of Medicine in 1976. A diplomate of the American Board of Family Practice, Dr. Snell has practiced family medicine in South Bend since 1979. He chairs the research committee for the Health Communities Initiative of St. Joseph County, an innovative project to assess and improve the community's overall health status.

In this interview, Dr. Snell shares his hands-on experience in

building successful POs, PHOs, HMOs and PPOs and gives practical advice to physicians.

**INDIANA MEDICINE: Tell us about the PO you have formed.**

**Snell:** The physician organization is Michiana Medical Associates. It was formed from the medical staff at Memorial Hospital in South Bend. We began recruiting members in late 1985. We had an open enrollment period when all physicians at the attending staff level were allowed to join at \$1,000 per physician. Ninety-two physicians signed up then. There was no strict credentialing process at that time. Then in 1986, we closed that open enrollment and instituted a credentialing process where physicians had to complete an application and be approved. We also increased the entry fee to \$1,250.

**INDIANA MEDICINE: Describe the credentialing process that followed.**

**Snell:** It was still fairly open. We have not maintained any sort of primary care-to-specialty ratio. We have always had trouble, of course, as all POs do, in getting enough primary care physicians. We have tightened the credentialing guidelines now so that you have to be not only an attending staff physician at the hospital but that you must also be board certified or board eligible after completing at least a three-year residency that has been approved by the American Board of Medical Specialties.

**INDIANA MEDICINE: How many physicians have you**





# PO, PHO formation

enrolled after the credentialing process started?

**Snell:** We currently have 240 members.

**INDIANA MEDICINE:** How is this PO governed?

**Snell:** We have a physician board made up of four primary care physicians from internal medicine, pediatrics and family practice; four from the other specialties; and one from ob-gyn. We maintain that mix of four, four and one.

**INDIANA MEDICINE:** What is your position with Michiana Medical Associates?

**Snell:** I currently serve as a board member and also the treasurer of the board. The board elects its own officers, and we have always had a primary care physician in the president's role. We only have four officers: president, vice-president, treasurer and secretary. We also have committees such as a credentialing committee and a utilization review/quality assurance committee that looks at utilization figures and financial figures on a monthly basis.

It also looks at any kind of quality issues that surface, such as complaints from patients about physicians or physician-to-physician complaints or incidents that may occur in the hospital or in the outpatient setting. Those are all reviewed in a blinded fashion. Periodically we'll have an ad hoc committee. We also pull together a fee committee near year end that looks at the RBRVS with multipliers for our fee schedules.

**INDIANA MEDICINE:** What was

the impetus for establishing this PO?

**Snell:** The purpose of the organization was to be a 50% owner in a health plan that was being started by Memorial Hospital. That was essentially our first PHO. As 50% owner in the health plan, the physician organization was needed to ante up enough capital to help get the health plan started.

“

*We measure success in terms of attracting members (covered lives), holding down costs and maintaining quality services.*

”

We created the organization, created a governance structure, and then we secured a 10-year promissory note from the hospital to help capitalize the health plan, Partners Health Plan of Indiana. Then there were two other hospitals, Elkhart General in Elkhart and Lutheran Hospital of Fort Wayne, that did the same with their physician organizations, so there are actually six shareholders in Partners Health Plan. Three are hospitals, and three are POs. Each shareholder sends two representatives to the Partners board of directors.

Partners Health Plan of Indiana is the third largest HMO in Indiana. We started enrolling patients on Jan. 1, 1987, and as of Jan. 1, 1995, we will have over 50,000 members in the HMO. In

1991, Memorial Hospital and Michiana Medical Associates came together again and created another PHO called Michiana HealthNet for the purpose of obtaining PPO business. That's been successful, too, and currently covers 12,000 lives.

**INDIANA MEDICINE:** How do you measure success?

**Snell:** We measure success in terms of attracting members (covered lives), holding down costs and maintaining quality services.

**INDIANA MEDICINE:** Are these organizations meeting your goals and objectives?

**Snell:** In 1986, HMOs weren't readily accepted. There have been some very good enrollment years and some that have been fairly flat. We became profitable after 18 months of operation on the health plan and have remained profitable ever since. When we started Partners, it was the fourth HMO in our area and by about 1990 or 1991, we were the only ones left. In terms of being competitive, we have weathered the storm.

But that doesn't mean there aren't more storms coming. We know we're pretty small. Fifty thousand lives is not a managed care giant by any stretch, but it's locally owned and all the decisions regarding utilization review, credentialing and medical policy are made locally.

**INDIANA MEDICINE:** What components of the PHO have been particularly successful?

**Snell:** Developing and owning the

health plan, number one. Developing good utilization review mechanisms and understanding risk, because through the HMO we have risk contracts and so the hospital is at risk, and the physicians are at risk. We have a risk-sharing mechanism, which means that if we hit utilization targets, then there is surplus in the physician pool and in the hospital pool. We share in the surplus. We also share in the deficits. We have had some years where the hospital pool was in deficit and the physician pool was in surplus, so we cross-subsidized. Then the very next year it was the opposite situation.

The other component that has been particularly successful is that the physician organization, Michiana Medical Associates, has been able to use part of its capitation from the health plan to fund its own activities. That includes paying physicians to come to committee meetings and board meetings and paying physicians to represent the physician organization on the health plan board. We also pay physicians to do chart reviews. Once a physician joins the organization, there are no annual dues or assessment. That was one of our goals. We have also been able to return, almost every year, 100% of the withholds. It's a 20% withhold, and we've never had a year where we've lost all the withholds.

**INDIANA MEDICINE: Have you had to make any major changes or refinements?**

**Snell:** For the physician organization, we have tightened up the credentialing, and we are in the process of looking at just how

many physicians we will need to be successful. Of course, we need primary care physicians, but we may do further refinement.

**INDIANA MEDICINE: What is the proportion of primary care versus specialists right now?**

**Snell:** Now we have about one-third primary care and two-thirds specialists, which is about the ratio in the other seven PHOs that were studied in the annual national PHO study conducted by the ISMA, the Michigan State Medical Society, the Illinois Medical Society and the AMA. Ideally, we would all like it to be 50-50. In the future, we probably will be admitting physicians to the PHO or allowing them to remain in the PHO based on economic and quality data. We need to develop better indicators of quality. That's a national effort. The problem is, most PHOs and even POs don't have the kind of information systems that define that kind of quality and economic data. They usually have more economic data than quality data. Quality is more difficult to define and obtain.

**INDIANA MEDICINE: Are you in the process of developing those quality data capabilities?**

**Snell:** Yes. We do have utilization data to look at physician patterns and resource consumption, and we can do some severity adjustment of the data. We also have the capability of doing HEDIS (Health Employer Data Information Set), which is a national standard being used now by many health plans to look at certain kinds of process indicators such as mammography rates, C-section rates, Pap smear

rates, immunization rates, patient satisfaction, etc. And because it's standardized now across the nation, you can compare your organization to another organization. We are doing that now at the aggregate level, at the physician organization level, but not down to individual physicians.

**INDIANA MEDICINE: What would you say is the minimum number of physicians necessary to form an effective PO?**

**Snell:** In rural communities, you're going to be faced with small medical staffs of 10 or 15 or 20, and even then a PHO can be formed. It really depends on what you want to do with the organization.

Even a couple hundred physicians really isn't enough if you're trying to cover a broad geographic area. If a small hospital medical staff wants to participate as a unit and accept risk, it could then partner with, say, a bigger organization. Not with a large payer, but it could align with a hospital where they refer a lot of their tertiary cases in a larger metropolitan area and could then become part of a larger hospital and physician organization.

I don't know if there needs to be a limit on the size. It depends more on what you intend to do. I think most of these organizations will want to, in some way, be linked with larger or regional networks so they can access managed care contracts. That seems to be the driving force.

If you are going to take on full risk, maybe a hundred physicians would be a good guess. You have to have an extensive enough network of specialty and primary physicians to handle most services.



**INDIANA MEDICINE: What else does a PO need?**

**Snell:** If the physician organization intends to do its own quality management, utilization review and credentialing, then it must have directors and officers insurance. Not malpractice insurance. It costs our organization about \$15,000 a year. So that may be the limiting factor, i.e., how many physicians must be in an organization to afford the premium payment on liability insurance.

I want to make sure that physicians know that they have to be protected because this is not malpractice. Some may think their malpractice policy would protect them, and it really doesn't. And the other thing is that the insurance policy never protects you against antitrust. The board members, particularly of a PO, have to be educated about the "safe harbors" and antitrust. We do give out information and reading material, and we discuss it so our doctors know. Of course, that's rapidly changing, but there are good attorneys that deal with physician organizations that can advise them.

That's another expense of a physician organization, good legal counsel, and it's not the hospital lawyer. It must be a lawyer who has the interest of the physician organization at heart.

**INDIANA MEDICINE: Is it difficult to get physicians to be on the board of directors?**

**Snell:** Initially, we had to draft people for the three-year term. Because of all of the turmoil and rapid changes taking place in medicine, it seems more physi-

cians are willing to serve and be involved. That's good. They want to have control, they want to have a say, and I think they realize that physicians don't have much of a say with insurance companies, for example. Some doctors may feel they don't have a voice in traditional hospital medical staff structures, so this gives them an opportunity to have a say, particularly as it pertains to managed

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*If the physician organization intends to do its own quality management, utilization review and credentialing, then it must have directors and officers insurance.*

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care.

Maybe a more important aspect of this is how do you develop physician leadership. Sitting on the board is a leadership position, but we need to go beyond that. One suggestion is to send some physician board members to educational meetings of the American College of Physician Executives. This is an excellent organization to help train physicians in skills needed to confront the challenges facing them – challenges of managed care, capitation, contracting and negotiations and so on. We just don't acquire those kinds of skills through our medical training so

we need to look at other educational efforts to learn this.

**INDIANA MEDICINE: What characteristics are needed to be effective on a board?**

**Snell:** You have to be objective, and you have to approach this from a big picture standpoint. It doesn't serve the organization well to have people on the board who are only interested in their own particular specialty or their own particular group or practice. The physicians need to put on their organization hat as opposed to their individual practice hat and then, even beyond that, put on a bigger hat that looks at the hospital and the community. You don't want to allow an "us versus them" attitude.

**INDIANA MEDICINE: What are the costs involved in the formation of a PO and a PHO?**

**Snell:** In forming a PO, it is extremely important that physicians are financially as well as morally and ethically committed to the organization. They need to understand what the organization will do for them. Therefore, you can't make the entry fee, in my opinion, \$200 or something like that. It probably needs to be at least \$1,000, and some PHOs are charging up to \$5,000. That seems high to me, but it needs to be high enough to get the commitment.

Then you also need some additional capital. Even with that amount of money per doctor, you don't have enough capital if you are planning to create your own health plan. Sometimes, promissory notes or loans are taken out. Then there are the types of on-

going expenses that we mentioned earlier, things like liability insurance.

Also, we decided up front to pay our physicians to attend board meetings and committee meetings and do chart review. That also helps increase attendance at the committee levels and maintains commitment.

If you're going into a joint venture like a PHO with a hospital, then a promissory note from the hospital may be necessary. If they expect to have 50-50 control, the physicians have to put up 50% of the money.

**INDIANA MEDICINE:** You said you have nine people on the governing board of the PO?

**Snell:** Correct. It should be an odd number, and it could probably get down to seven, maybe five for a PO. I wouldn't want to make it any more than 11 or 13. I think you want adequate representation of primary care and specialties. Now, a lot of consultants and advisors say it should be dominated by primary care, so there may be an unequal amount of seats on the PO board in favor of primary care. That creates some problems, but it may be successful, depending on each location. For the PHO, the hospital and the physician organization have to have an equal number of seats. The president of the PHO board would probably alternate between the hospital side and the physician side each year. Another step I would take on a PHO board is to bring in community representation.

**INDIANA MEDICINE:** What should specialists do to protect their practice since most managed

care organizations make patients go to the primary care physician first?

**Snell:** First of all, specialists have to be part of a PHO or PO. Some of them are refusing. They say they don't have to join because they're going to get the patients anyway. That may be true if they're the only game in town, but that will probably change. If they are outside the physician organization or the PHO, those organizations

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*The board members, particularly of a PO, have to be educated about the 'safe harbors' and antitrust.*

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are going to be awarded contracts, and there is no guarantee that those specialists will see these patients. Specialists have to become the primary care physician's friend, not enemy.

A lot of specialists are unhappy about the power, the control, that primary care physicians are gaining, and they are resisting changes. I don't think that's in their best interest. That attitude will probably hurt them in the long run. I think first they should offer quality services. That means be available, communicate well with good progress reports and follow-up letters and consultation notes; be very responsive to the needs of the primary care physician as well as the patient; and treat them both as well as they

can because it's in everyone's best interest.

**INDIANA MEDICINE:** What kind of management expertise is required to run a PHO and an HMO?

**Snell:** When we formed our health plan or HMO, we made substantial investment in information systems and staff. Then in 1991, we put together Michiana Health Net, which was a PPO and required significantly less capital. We ran that with three or four personnel, not even full time, and an information system that really didn't cost that much because all we were doing was repricing claims. If you just want to be a PHO or PO that joins with, say, a large insurer and you rent the network to them, then you need minimal staff. You should at least have a part-time medical director. It really depends on your objectives and goals in terms of how much management you need.

**INDIANA MEDICINE:** Where do POs and PHOs fit in the trend toward managed care?

**Snell:** POs and PHOs are probably transition organizations between where we are now – our traditional fee-for-service, independent practice models where the delivery system is very fragmented – and a true integrated delivery system that is accountable for cost, quality, access and improving the health status of a population. That's where we're going. Whatever we do, we have to keep the vision of that kind of organization. There's going to be a learning curve, and many PHOs and POs will fail because there's too much



variation in the cultures, and the economic, utilization incentives are not truly aligned.

But doing nothing is even worse. Even though we are going through a painful transition, it is in the best interest of physicians to join some type of an integrated unit, however loose or tight that may be.

Right now, Michiana Medical Associates is forming another PHO with Memorial Hospital. We have a governing structure in place and will be doing direct contracting with employers. It's a transition organization, but it should be successful because we have eight years of experience. I'm very thankful for that, but we've got many challenges ahead of us also.

**INDIANA MEDICINE: Do you**

**have any advice for physicians who are contemplating joining a PO or PHO?**

**Snell:** Number one, they need to be selective. I don't think they should go out and join every PHO or PO that offers them the opportunity. Some will be under-capitalized; they won't have adequate governance structures; they may be dominated by specialists or by a hospital.

Number two, they have to make sure that physicians have a say in the governance, not lip service.

Number three, I don't think they should ever contemplate joining an organization that talks about keeping out managed care or avoiding capitation. Physicians should be focusing on those two

issues now and realize managed care and capitation will be part of their future.

Number four, physicians have to think about an integrated delivery system that's held accountable for cost, quality, access and improving health status. It is going to be very difficult to accomplish these goals at an individual physician level. Yes, it may mean relinquishing some of their own decision making and losing some autonomy, but in the long run it's going to be a better system. □

*The author is a health care writer in Indianapolis.*

# ISMA program helps with practice-related problems

**H**ealth system reform is causing Indiana physicians to take a closer look at their practices. An ever increasing number of physicians are being required to make crucial decisions that could determine whether or not they will continue to practice medicine.

Because the ISMA believes Indiana physicians deserve the best and most accurate information available to remain competitive in the health care market, the ISMA has created the Physician Organizational Management Consulting (POMC) program to answer practice-related questions. The service is free to ISMA members.

The ISMA began the program as a result of the changes in health care delivery. Because many decisions made under confusing and uncertain conditions can lead only to disaster for the physician, the medical practice and the community, the ISMA wants to give members information needed to make wise business decisions. The POMC program brings together experts from the legal and financial fields to help physicians make those decisions based on sound advice.

Physicians with questions may call Tim Brent, the ISMA POMC representative, at (317) 261-2060 or 1-800-257-4762. He will refer physicians to the appropriate consultant.



Brent

The four firms that are providing consultants for the program are Blue & Co. and Heaton & Eadie, accountants and health care consultants, and Hall, Render, Killian, Heath & Lyman and Krieg, DeVault, Alexander & Capehart, law firms.

To introduce the program consultants to ISMA members, *Indiana Medicine* asked the consultants for their views on issues related to health system reform. Consultants interviewed were Michael N. Heaton, C.P.A., Heaton & Eadie; Kameron McQuay, C.P.A., Blue & Co.; Thomas R. Neal, J.D., Krieg, DeVault, Alexander & Capehart; and Kevin P. Speer, J.D., Hall, Render, Killian, Heath & Lyman.

**Q. How can the Indiana physician prepare for the changes that will take place in health care reform? Is there a proactive approach that can be taken?**



Heaton

organizations (networks, alliances, etc.) continue to develop, it is important that Indiana physicians understand the options available to them. It is important that all options be weighed in conjunction with a thorough understanding of existing practice patterns.

**Heaton:** Changes in health care will take place on a variety of different fronts. As these various forms of business

**McQuay:** There are many things that a physician can do to prepare for change. First, physicians must recognize that change will occur and such change will occur on many fronts (i.e., financing, technology, etc.). However, nowhere will it be more pervasive than in the delivery structure of our health care system. In order to prepare for this new structure, physicians must:

- Increase efficiencies throughout their office. This includes cutting overhead expenses, increasing staff utilization and utilizing physician extenders.
- Focus on revenue streams, not just costs.
- Implement the best cost accounting and information system available.
- Learn how to preserve and increase quality while reducing costs.
- Reinforce market position by affiliating or establishing a network or integrated system.
- Begin to get experience in small managed care plans and capitated environments.
- Invest in your practice.

**Neal:** Market reform is based in managed care/competition principles of reducing cost to the consumer or purchaser of health care services. Initial cost reduction will come from reducing inpatient hospital stays. Further reductions will come from specialty physician services and general "overutilization" of physician services. Physicians should begin to take steps to quantify their time and costs of producing services. The knowledge of cost of service



should be coupled with leverage in contract negotiation based in size and quality (reputation). These tools will help the practitioner to control his own destiny.

**Speer:** Physicians in Indiana can best prepare for the changes by "getting bigger." One way physicians "get bigger" is by integrating their practices. By getting bigger, physicians increase their value to the large systems that are evolving in Indiana. The more valuable the physician, the more likely the physician will be able to demand a meaningful voice in the structure and management of the systems as they come together.

Physicians should take a proactive approach when preparing for health reform. In today's market, a physician must learn how to negotiate with managed care plans. The days of blindly signing managed care contracts and simply "trusting the system" are over. Physicians must also learn to capture and use data in order to market themselves. The future of health care in Indiana promises to create winners and losers. It is critical that physicians be able to "sell themselves" to the winning managed care plans. Physicians might also consider forming and operating local managed care networks.

**Q. What are some mistakes you have seen physicians make in attempting to reposition themselves in the market?**

**Heaton:** The primary mistake here is one of haste without all the available data. Several physicians have repositioned themselves under the "bigger is better" theory. As a result, affiliations have

developed that have proved to be very costly in terms of initial set-up without the prospect for much patient steerage.



**McQuay**

are complex and diverse. While I think it is clear that some action needs to be taken, you can fall off a log both ways. The two extremes I have seen include: physicians putting forth absolutely no effort to reposition their practice, i.e., business as usual or denial nothing is going to change, or the opposite end of the spectrum, a "sell, sell, sell" mentality.

It is essential in structuring long-term goals for your practice that traditional but obsolete ideas are no longer embraced. This would include strategies to increase volume or procedures or plans to fill hospital beds. Instead, thinking in terms of covered lives, increased efficiencies, patient services and equipping the system to meet customer demands and expectations should prevail. Recognize change and know what you can control and what you cannot. This requires a long-term focus.



**Neal**

**McQuay:** There is no formula or book outlining four easy steps on how to succeed in today's health care market. The dynamics

Another problem is the expenditure of time and money on a new partnership or structure without a market analysis or business plan. Physicians should put together a team of professionals they trust for advice and assistance, just as they would in a business venture unrelated to their practice.



**Speer**

**Speer:** The No. 1 mistake physicians in Indiana are making is deciding not to reposition themselves in the market.

Some physicians have refused to acknowledge the coming changes in health care delivery. Others still want to trust the system to protect them.

Physicians who are attempting to reposition themselves in the marketplace must remember to be patient and to not look for immediate tangible benefits of "getting bigger." It will take time for the marketplace to adjust to the new delivery systems, and physicians must be patient. Physicians also should try not to worry about too many insignificant details when trying to integrate. Certain aspects of getting bigger will have to be worked out once the market has adjusted to the new delivery system.

**Q. How does the rural practice environment differ from the urban practice environment?**

**Heaton:** Change in the rural practice environment seems to be primarily driven by the development of physician hospital organizations. If the PHO does emerge in

Indiana as one of the contracting entities of choice, it will be important for rural practitioners to continue to nurture these types of relationships.

**McQuay:** There are true distinctions between urban and rural practices. Many of these distinctions, for example, the shortage of primary care physicians, will remain intact no matter what type of health care reform occurs. The delivery of health care is and will remain a local/regional issue. Therefore, local employers and local hospitals will play the primary role in developing health care systems for a particular community. However, it is errone-

ous to assume that managed care will not affect practices in the rural environment.

Initially, managed care will be more prevalent and integrated in urban or metropolitan areas, but will slowly progress to rural areas. The growth of capitated plans will always be hindered in rural areas due to the lower concentration of patients and payers.

**Neal:** Less overt competition is a factor in communities with one hospital. Nevertheless, the hospital may openly compete with physicians or assume a "lock-out" philosophy regarding its network. Rural areas present fewer choices for affiliation among physicians to

respond to network pressures. Perhaps a regional view of affiliations would be beneficial.

**Speer:** The most significant difference between the rural practice environment and the urban practice environment is that there is usually less competition in the rural setting. This lack of competition may affect rural practitioners' strategies in approaching and positioning themselves in the marketplace. For example, it may be possible for the rural practitioner to become an indispensable component of all networks/plans in town. □

## ■ drug names

### Look-alike and sound-alike drug names

	<b>RIMANTADINE</b>	<b>RANITIDINE</b>
Category:	Antiviral agent	Histamine H <sub>2</sub> antagonist
Brand name:	Flumadine, Forest	Zantac, Glaxo and Roche
Generic name:	Rimantadine HCl	Ranitidine
Dosage forms:	Tablets, syrup	Tablets, syrup, injection
	<b>DARVON</b>	<b>DERVROM</b>
Category:	Narcotic agonist analgesic	Antidiarrheal
Brand name:	Darvon, Lilly	Devrom, Parthenon
Generic name:	Propoxyphene HCl	combination product
Dosage forms:	Capsules	Tablets (chewable)

**Benjamin Teplitsky, R. Ph.**  
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □



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and quality service  
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With strength, stability and an uncompromising commitment to quality, First American has developed into the nation's largest, privately-owned, Medicare-certified home health care provider. We have now changed our name to reflect this growth. First American Home Care is now located in 21 states from coast to coast, with over 400 home

health agencies and 13,000+ of the nation's most talented professionals. Poised for the 21st century, we will continue to provide the finest home health services available...anywhere.

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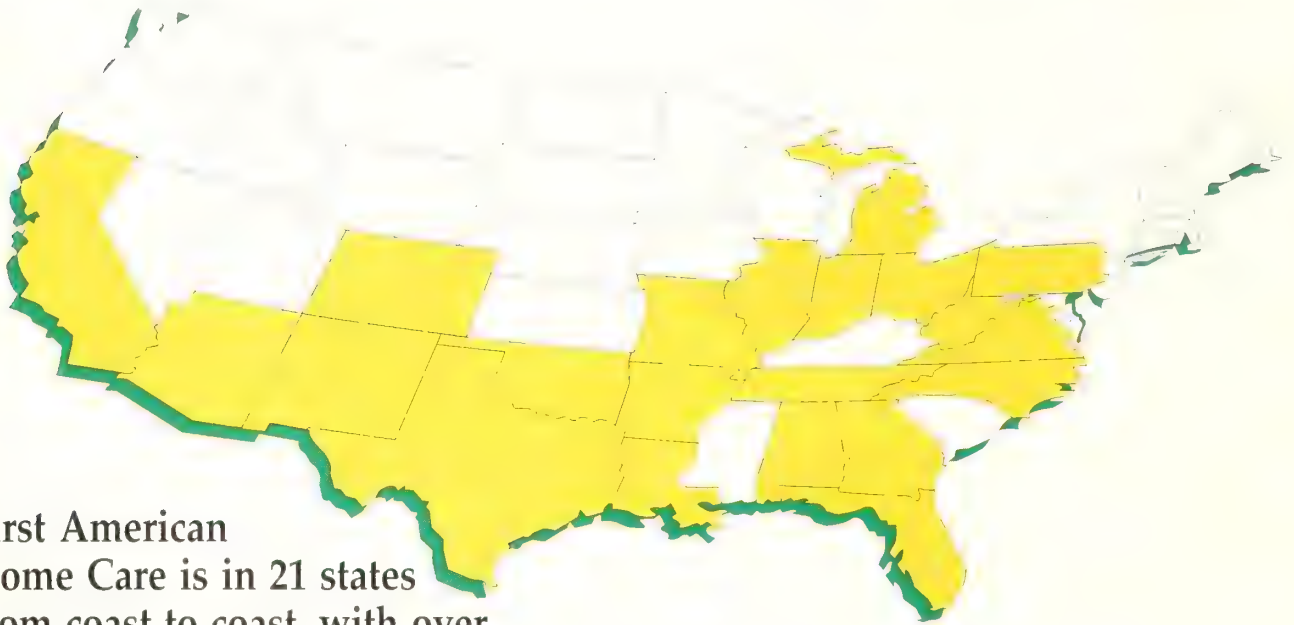
They brought to our company a depth of management and medical expertise unmatched in the industry.

Our company has proactively changed over time. With strength, stability and an uncompromising commitment to quality, we have developed into the nation's largest, privately-owned, Medicare-certified home health care agency.



**ABC Home Health Services, Inc.**

## is now First American Home Care.



**First American  
Home Care is in 21 states  
from coast to coast, with over  
400 home health agencies and  
13,000+ of the nation's most talented  
professionals.**

First American offers the resources of a large, national firm. Yet, locally based and community focused, we make a difference in the lives of people across America as we continue to keep families together.

Now, stronger and more efficient than ever, we salute our employees. They have made us the industry leader that we are today. Poised for the 21st century, we will continue to provide the finest home health services available... anywhere.





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Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Managed Health Plans and the corporate affiliate of Arnett Pharmacy.

## **P**ractice Setting

At this time, over 110 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

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## **C**ommunity

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

## **F**or further information...

about Arnett Clinic and physician employment opportunities contact:

Physician Recruitment Department  
Arnett Clinic, 2600 Greenbush Street  
Lafayette, IN 47904 (317) 448-8000  
Toll Free Nationwide, 1-800-899-8448



*Lafayette, Indiana*

# ISMA pursues full legislative agenda

**Mike Abrams**  
ISMA Director of  
Government Relations

No one predicted such a landslide victory for the Republicans, although most agreed that it would be a strong Republican year. When the votes were tallied and the winners announced, the Republicans grabbed control of the Indiana House of Representatives, the Indiana Senate, the U.S. Congress and the U.S. Senate.

For the first time since Ned Lamkin, M.D., left the House of Representatives in 1982, a physician was elected to the Indiana legislature when Tim Brown, M.D., a family physician from Crawfordsville, was elected to serve in the House from House District 41.

Two incumbent Democrat Indiana Congressmen were defeated (Mark Souder [R] beat incumbent Jill Long [D], and John Hostetler [R] beat incumbent Frank McCloskey [D]), and a Democrat open Congressional seat went Republican when David McIntosh (R) beat Joe Hogsett (D) for the seat that was vacated when Phil Sharp (D) decided not to seek re-election.

On top of that, consider the Republican gubernatorial victories around the country as significant gains for the GOP: Thirty of the nation's governors are Republicans.

The changing political landscape will likely have an impact on the lobby efforts of virtually every major group on most every issue. The exact nature of that impact remains to be seen, as it is difficult

to assess which groups were empowered and which were weakened by the election results.

At the federal level, one might expect that the legislative agenda for the trial lawyers association would be made more difficult by the Republican takeover because Republicans were generally more supportive of more broad-based tort reform efforts in the health reform debate. Likewise, however, the election was probably good for the tobacco industry, which had been under considerable attack from the Democratic White House as well as a number of influential Democratic Congressmen. It is widely believed that the Republicans in Congress will not be as aggressive against the tobacco industry as the Democrats have been during the past few years.

There was massive turnover in the Indiana House of Representatives, with 18 incumbent state representatives not returning. Many of those who are not returning were very influential over health issues, including House Speaker Mike Phillips and Health Committee members John Day, Ben GiaQuinta and George Schmid.

Rep. Paul Mannweiler, elected speaker of the House on Organization Day Nov. 22, has cut the number of committees, which will likely result in a major change in committee assignments on some committees that are important to health care.

On Oct. 4, the Republican House candidates signed a "Contract with Indiana" outlining the principles by which they will be guided as they lead the state House of Representatives. One of



**Mannweiler**

the principles speaks to health care: "Enact market-based reforms in health care and Medicaid to increase choice and control costs, while avoiding further socialization of health care in Indiana." Republicans committed themselves to acting on this and nine other principles within the first 30 days of the 1995 legislative session.

In the state Senate, the turnover was far less dramatic. Only three incumbent senators will not return. Committee assignments and leadership positions are not expected to change significantly in that chamber.

**ISMA has a full legislative platter** Indiana physicians, through the ISMA, will ask state legislators to pass a large number of bills during this upcoming legislative session. Some of those bills are listed below:

- Patient Protection Act – Federal legislation sought by the AMA to protect patients from unfair insurance prac-



## House members not returning

Brad Bayliff (R-Kokomo)

Pete Beck (D-Marion)

\* Joyce Brinkman (R-Indianapolis)

Paul Cantwell (D-Indianapolis)

\* Jack Cottey (R-Indianapolis)

\* John Davis (D-Logansport)

John Day (D-Indianapolis)

Ben GiaQuinta (D-Fort Wayne)

Ed Goble (D-Batesville)

Linda Henderson (D-Bedford)

Earle Howard (D-Kokomo)

Jerry Kearns (D-Terre Haute)

\* John Matonovich (D-Hammond)

Mike Phillips (D-Boonville)

\* Dan Pool (R-Crawfordsville)

\* George Schmid (R-Indianapolis)

Vern Tincher (D-Terre Haute)

\* Fred Wenger (R-Muncie)

## Senate members not returning

Maurice Doll (D-Vincennes)

Larry Macklin (D-Decatur)

Bill Soards (R-Indianapolis) □

\* *Member did not seek re-election to the House*

tices was unsuccessful, but several states are preparing to pursue state legislation to accomplish the same goals. The California Medical Association successfully lobbied legislation that protects patients, and the ISMA will introduce a similar bill during the 1995 session. The Indiana bill will require insurers to disclose to patients the extent of their coverage, including those things that their premiums will not cover. Addition-

ally, if a managed care plan intends to de-select a patient's physician, the physician must be told why he or she will not be permitted to see patients in the plan. Plans will not be allowed to dismiss physicians for providing care that patients need.

- **Corporal punishment** – Indiana legislators will again be asked to enact legislation to prohibit corporal punishment in Indiana schools. Similar legislation has failed to become law in the past two legislative sessions.
- **Tobacco** – The ISMA will cause to be introduced a bill that will restrict the display of tobacco products in prominent areas of retail stores, prohibit vending machine sale of tobacco and license retailers who wish to sell tobacco products.
- **Good Samaritan** – Legislation will be filed to change the Good Samaritan statute so it can be applied in emergency situations, as well as at accident sites.
- **Medical Licensing Board** – Legislation will be introduced that requires physicians be notified by the state before the state can summarily suspend a medical license.
- **State action anti-trust exemption** – The ISMA will seek legislation to relax anti-trust threats against physicians who form networks to compete with networks organized by insurance companies and other entities.
- **Domestic violence** – Legislation to require information on spouse abuse to be provided to couples at the time marriage licenses are applied for will be



**Timothy Brown, M.D.**, a family physician from Crawfordsville, is sworn in as the state representative from House District 41. Dr. Brown, a Republican, is the first physician in the Indiana General Assembly since Rep. E. Henry Lamkin, M.D., (R-Indianapolis) who served from 1967 to 1982.

pursued by the ISMA, as well as a bill to require child abuse information to be provided to new parents.

- Insurance reform – The health insurance industry would be reformed under legislation to be sought by the ISMA. The bill will put restrictions on the ability of insurance policies to exclude pre-existing conditions from coverage and will seek other reforms of the insurance industry.
- Medicaid – An “anti-hassle” bill will be pursued by the ISMA, which will make it administratively easier to work with the state Medicaid program. This legislation becomes increasingly important as the reimbursement

under Medicaid continues to decline. Medicaid expenditures to physicians increased from \$200.2 million in 1993 to \$211.5 million in 1994. This increase is much smaller than has been experienced in past years and reflects the current administration’s aggressive approach to cutting the Medicaid budget.

#### **ISMA Grassroots “Key Contact” program up and running**

The ISMA continues to encourage and facilitate the involvement of individual physicians and physician spouses in the legislative process through the Key Contact program. This program uses a “peer-to-peer” technique to urge quick action on issues important to medicine.

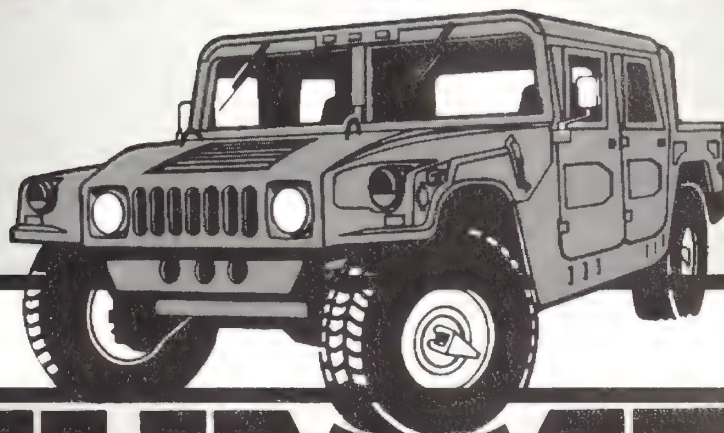
The Key Contact program is

organized at the county level, with a telephone tree designed for each county. When legislative contacts are needed, a Key Contact alert is issued, and point physicians are notified by the ISMA via a fax machine. Those point physicians then contact their legislators and contact the physicians to whom they are assigned, asking those physicians to make contact with the legislators.

It is critical that participation be widespread for the Key Contact program to work effectively. If you are not enrolled as a Key Contact physician, call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762. Once enrolled, you will receive a Key Contact kit with information on how to participate effectively. □



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# ISMA presents results of Strategic Health survey

**Tim Brent**  
**ISMA Data Analyst**

The ISMA Strategic Health survey was created to give the ISMA and member physicians more information about the active member population and to help build an information database. Other state medical societies were solicited for information concerning their respective survey projects. These societies provided the ISMA with information about previous data projects, which aided in the development of the survey.

To ensure that the goals of the ISMA were achieved, a private consulting firm reviewed the questions and method of surveying members. The survey was then refined and mailed to selected physicians for testing purposes.

After testing, the questionnaire was mailed to all active ISMA members who had been practicing medicine for one year or more in Indiana. Out of 6,006 active members surveyed, 1,606 valid surveys were returned, with an overall response rate of 26.7%. At a reliability rate of 90%, the margin of error was 1% to 1.5% for the total population representing a valid sample.

Following are some of the key findings of the ISMA survey:

## **Demographics**

- Gender response was 87.9% men and 12.1% women.
- Ages of respondents ranged from 27 to 70 years.
- Average age was 47.92 years.
- The average respondent had been practicing medicine for

16.76 years.

- Physicians from 59 different specialties responded to the survey.
- 94.3% of the respondents are registered to vote.

## **Practice assessment**

- Of those physicians in a group setting, 77.7% were in a single specialty group.
- Respondents in partnership and group practices indicated the number of physicians in their practices to be between two and 122 physicians.
- 24.3% of the respondents are considering changing their organizational arrangement in the next two to three years.
- The average number of physicians practicing in a partnership or group was 17.16.

## **Third-Party payers**

- 76.4% of the respondents participated in Medicare through the 1994 participation agreement, and 13.5% accepted assignment on a per case basis.
- 46.3% of the respondents believed that the number of Medicare patients seen at their respective practices would increase, while 43.3% believed it would remain the same. A decrease in Medicare patients was projected by 3.3% of the respondents, and 7.1% were unsure.
- 63.5% of the responding physicians accepted Medicaid patients without limiting the number seen.
- 24.4% did limit the number of Medicaid patients seen, while

12.1% did not accept Medicaid patients.

- The main reason for limiting or not seeing Medicaid patients was reimbursement.
- Pre-paid program participation (HMO) was 67.1%.
- 54.4% of the respondents stated they would very likely participate in an HMO or similar agreement during the next two or three years, and 18.8% probably will participate. At the time of the survey, 12.9% of the respondents were still considering participation in a pre-paid program.
- Review by a third-party payer resulted in the denial of compensation for already rendered care or other sanctions for 74% of the respondents.
- The most frequently used reason for denial of compensation for already rendered care was non-coverage issues with 70.9% of the responses.
- The primary method of submitting claims to third-party payers was through: the use of an in-house computer system that billed directly to payers (49.0%); paper claims sent directly to payers (27.7%); paper claims sent to a billing service (13.7%); and electronic claims sent to a billing service (9.5%).

## **Computers**

- 63.6% of the respondents personally use a computer.
- 89.1% of the respondents' medical offices use computers.
- Of the 10.9% of the respondents whose medical offices did not have a computer,



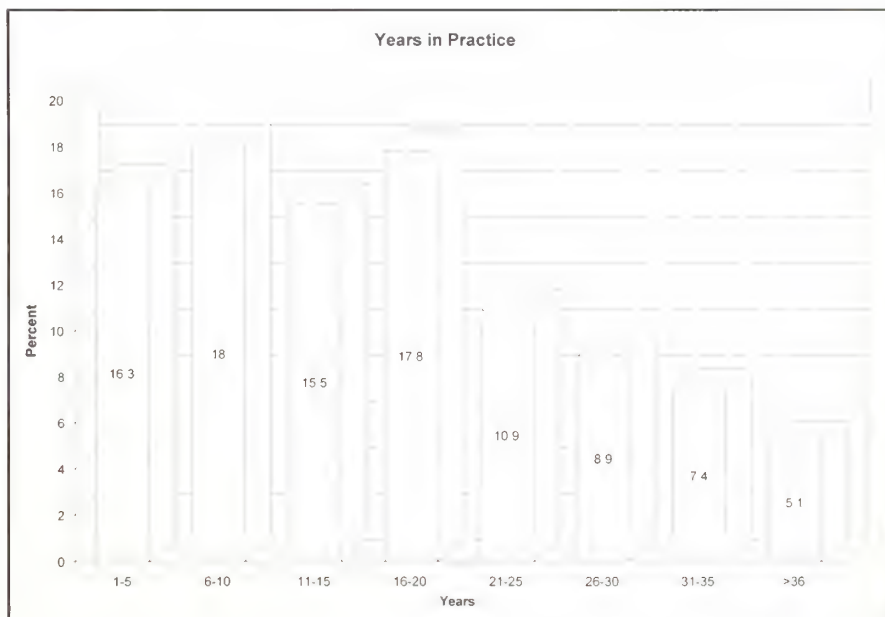
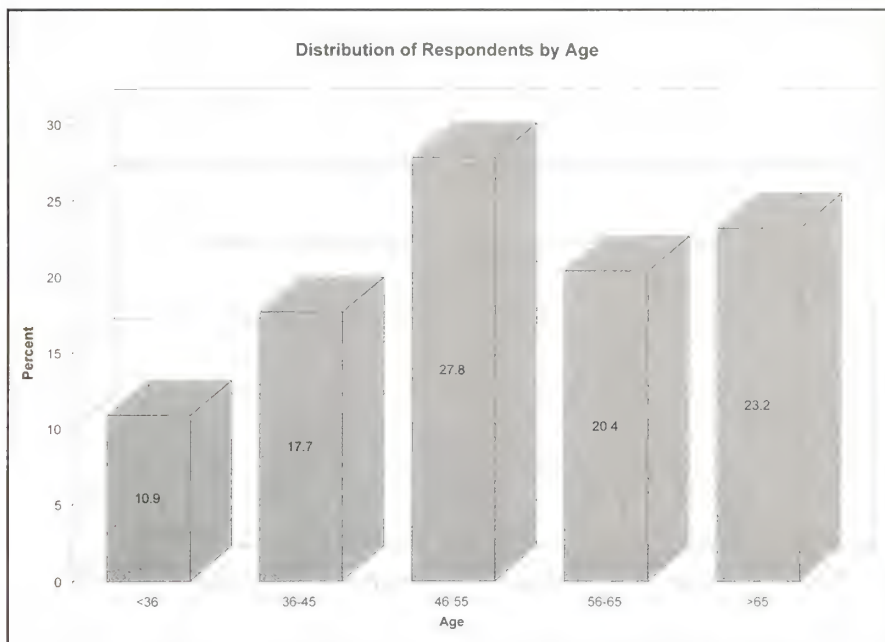
41.3% felt it was due to the expense of purchasing and maintaining the system.

- Of the 10.9% of the respondents whose medical offices did not have a computer, 25.6% planned to computerize the office within the next two years, and 32.5% were unsure.

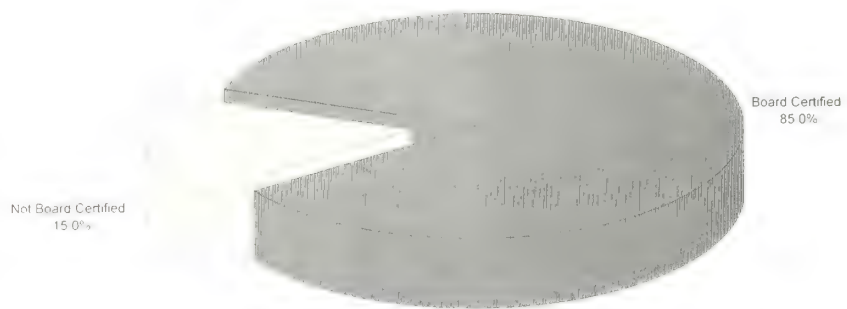
#### Liability

- 64.9% of the respondents individually purchased insurance through an insurance carrier.
- 57.7% of the respondents have had a medical liability suit brought against them during their career.
- 60.8% were dropped before going to trial, 24.2% were settled before or during trial, 2.4% received a judgment of liability, and 12.6% were still unresolved.

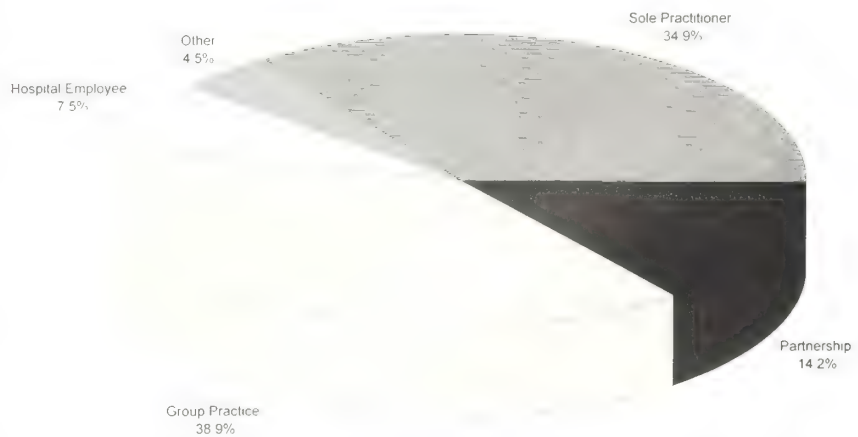
For more survey findings, turn to pages 24, 25, 26 and 27. □



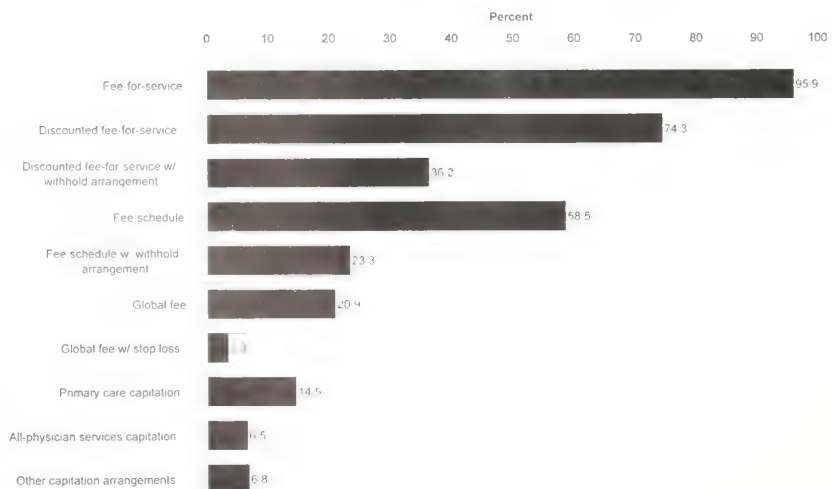
Board Certification of Respondents



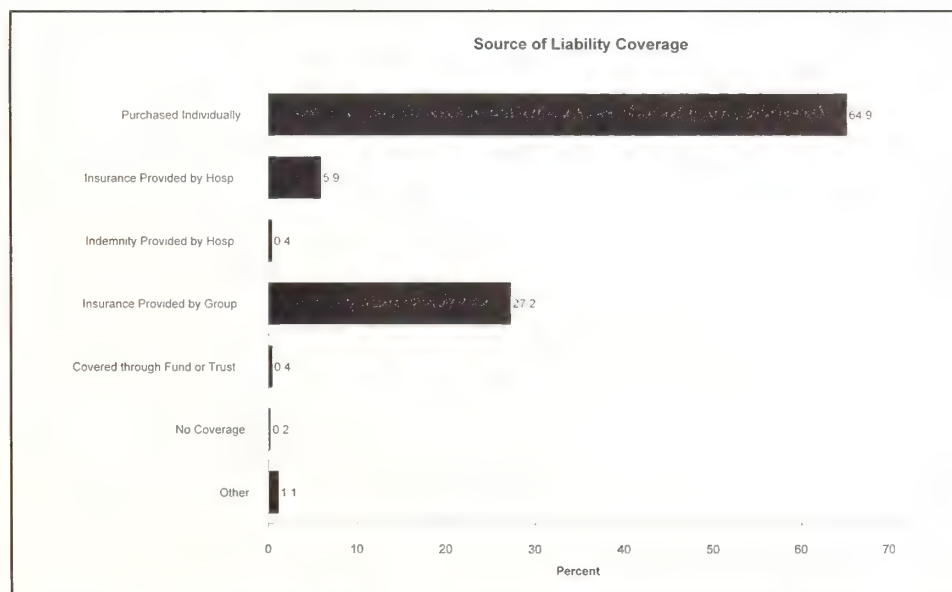
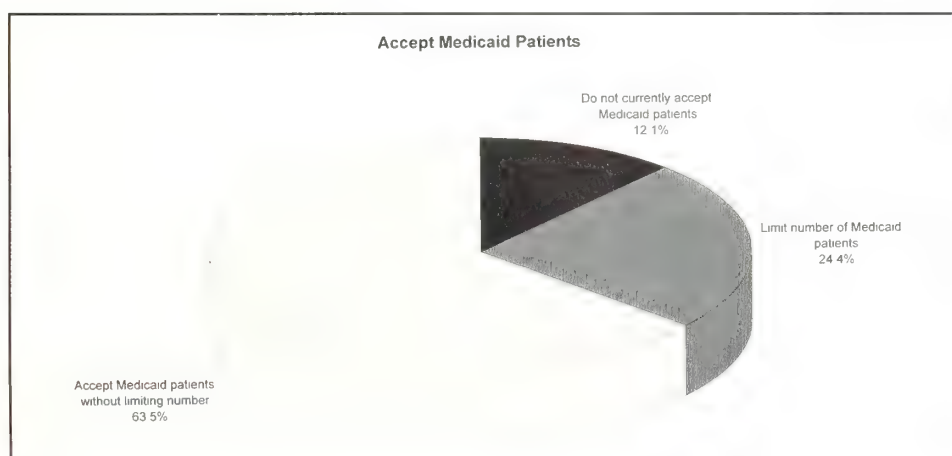
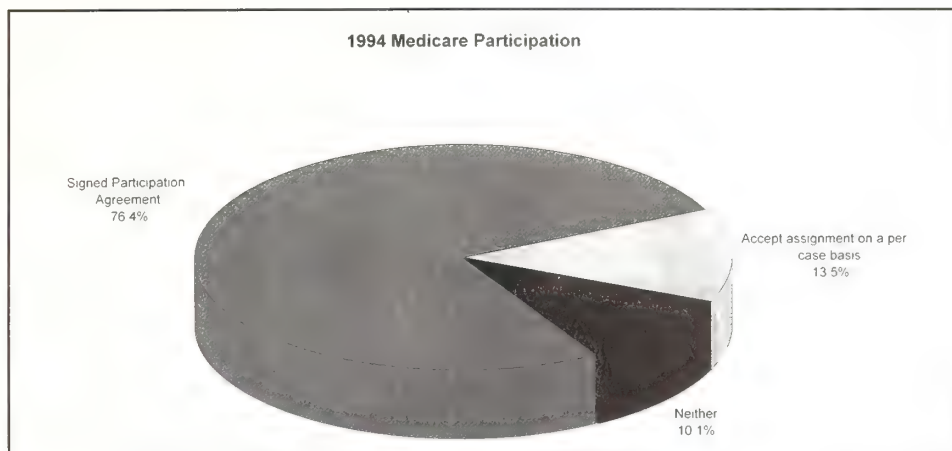
Current Organizational Arrangement

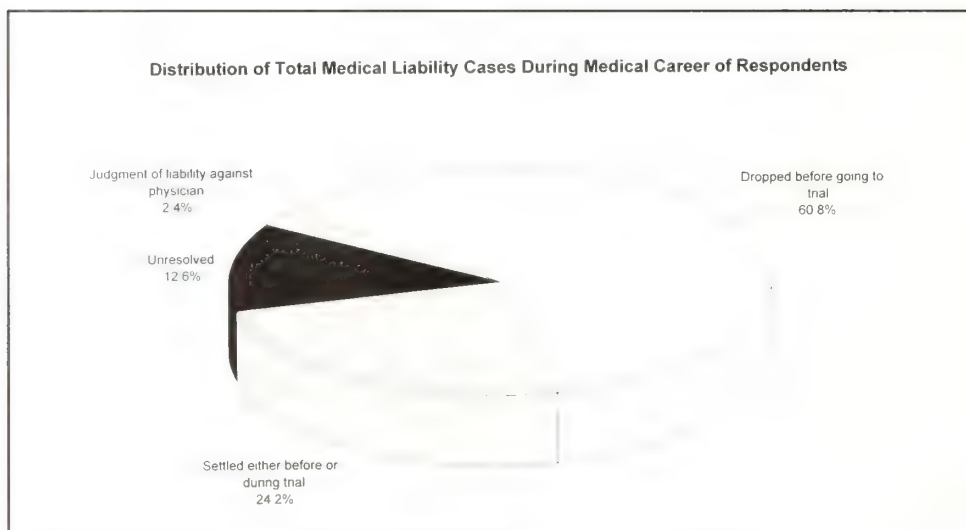
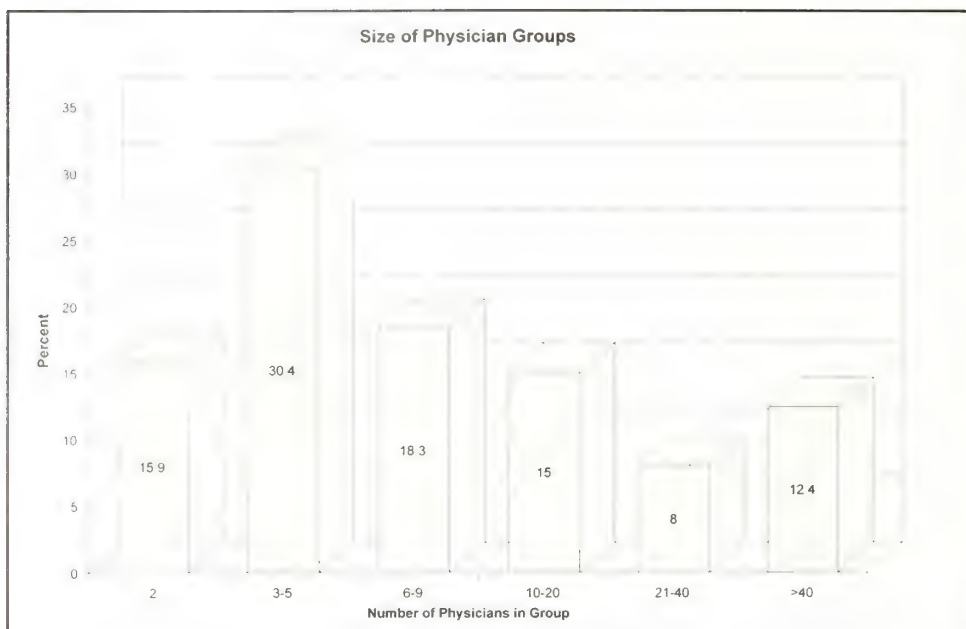


Physician Reimbursement by Category











(In Thousands of Dollars)	TOTAL EXPENSES				*NET INCOME				TOTAL BAD DEBT		
	Mean Range		Number of Responses		Mean Range		Number of Responses		Mean Range		Number of Responses
ALL PHYSICIANS	164.54	191.16	1299		188.93	216.26	1335		25.07	26.70	1260
SOLO	144.55	176.06	531		163.46	190.97	523		20.21	21.87	512
NON-SOLO	178.36	204.37	768		205.34	232.55	812		28.39	30.01	748
AGE											
<36	148.88	175.46	129		143.14	171.73	139		18.70	20.46	132
36-45	169.64	196.18	476		207.15	234.35	483		25.97	27.63	457
46-55	187.08	213.66	365		214.11	240.96	377		29.51	31.12	353
56-65	143.70	170.57	261		160.69	188.06	267		23.19	24.72	253
>65	117.43	144.12	68		125.32	153.48	69		14.75	16.51	65
SPECIALTY											
AN	37.51	64.10	83		213.07	242.07	82		22.01	23.79	82
EM	55.50	80.00	20		182.74	211.74	23		47.85	48.65	20
FP	146.50	174.14	286		111.97	140.10	300		15.64	17.37	279
GS	120.89	149.89	88		200.26	227.30	89		28.60	30.22	85
IM	151.82	178.77	114		141.88	169.92	121		17.56	19.29	108
OBG	202.63	230.67	90		220.74	249.08	88		25.30	27.02	87
OPH	262.83	285.85	47		222.44	248.22	45		17.28	19.19	47
ORS	290.85	315.08	75		313.81	337.72	74		47.10	48.44	70
OTO	252.44	276.26	43		247.26	274.40	47		24.55	26.32	44
P	64.50	92.00	40		122.82	151.05	38		20.80	22.30	40
PD	138.92	166.57	65		125.06	153.63	68		18.24	20.05	63
R	173.00	197.74	23		256.44	282.22	27		52.74	53.87	23
U	206.94	234.13	32		224.14	251.49	35		21.94	23.59	34

\*Net Income (after expenses before taxes)

For the approximation of total expenses, net income and bad debt, ranges of dollar amounts were given as possible responses. The mean ranges were determined by calculating the means for the lowest possible values in each answer and then by the highest possible values. If the physician was part of a group, the physician was requested to record his or her share for each question.

# Survey of influencing factors to a career in family medicine

Gary J. Keepes, M.D.  
Evansville

Over the past 20 years, it has become apparent that the supply of health care providers is not meeting the health care needs of the nation. It has been well publicized that there is an oversupply of specialists and not enough primary care physicians. In the 1970s, efforts to produce more primary care physicians were supported by the creation of primary care programs in medical schools and residencies in family medicine. More recently, efforts on the national, state and local levels have included President Clinton's new health care reform, the Indiana Commission on Higher Education report and the addition of a third-year clerkship in family medicine to the Indiana University School of Medicine curriculum.

What factors attract students into the primary care discipline of family medicine? Which of these two factors influence career decision the most: role models or clinical experience? What characteristics predispose a medical student to choose family medicine? The purpose of this study is to answer these questions and identify the type of student that enters family medicine and the factors that play into this career decision.

## Background

Two approaches have been taken to increase the number of students entering family practice residencies: identify applicants to medical school who have certain characteristics that predispose them to

choose family medicine residencies and to change the medical school curriculum so as to positively influence medical students' career choice toward family medicine. Many studies have attempted to identify characteristics that might predispose a student to enter family medicine. Cole et al<sup>1</sup> found that applicants favoring family medicine are most likely male, married, Protestant and somewhat older than their peers. If an applicant is from a small town or rural background and has attended a public college for undergraduate studies, he is more likely to choose family medicine.<sup>2</sup> Also, students who entered medical school with an interest in family medicine were almost three times as likely to choose family medicine as a career than students who were interested in other specialties.<sup>3</sup>

Students interested in primary care were more oriented toward considering the sociopsychological context of patients' problems and were more likely to perceive a need for change to improve health care in the United States.<sup>4</sup> Rosenthal et al<sup>5</sup> examined income expectations of first-year medical students as a predictor of family practice as a career choice and found that students<sup>8</sup> who had a lower income expectation during their first year were more likely to choose family medicine residencies.

Multiple studies have also examined medical school curriculum and how it relates to family medicine career decision making. It has been shown that students who attend a medical school with a required clerkship in family medicine are more likely to enter

family medicine residencies.<sup>6-11</sup> Godkin et al<sup>10</sup> also found that the fourth-year curriculum was considered to be very important in the decision-making process. However, Allen et al<sup>12</sup> found that early exposure to role models in family medicine during the first and second years of medical school did not have a significant effect on the student's choice of family medicine as a career.

## Methods

This study focused on the 259 fourth-year students at the Indiana University School of Medicine. A four-page survey was mailed to each student. The survey was divided into three sections. The first section dealt with groups of people and their influence on the students' decision whether or not to enter family medicine. The next section asked what attitudes were expressed by the different specialties during the required third-year clerkships toward family medicine as a career choice. General student background information was obtained in the third section. This included age, gender, marital status, number of children, ethnic background, amount of debt after medical school, population of hometown, occupation of parents and where the first two years of medical school were completed. Surveys were put in each student's mailbox during the last week in September. A reminder notice was placed in the mailboxes during the middle of October and a second mailing to non-respondents went out at the end of October.

Each returned survey was precoded to aid in data collection and analysis. Data were entered in

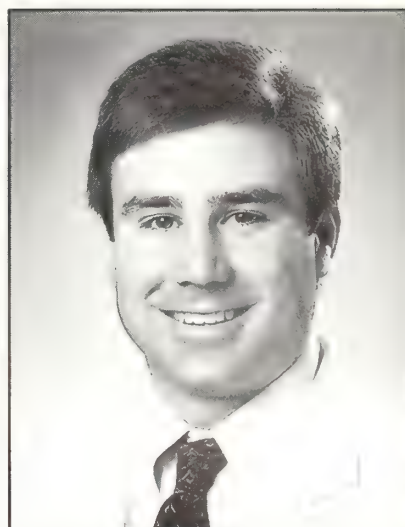


## First winner of Frank Ramsey, M.D., Writing Award named

**G**ary J. Keepes, M.D., a family practice resident at Deaconess Hospital in Evansville, is the first recipient of the Frank B. Ramsey, M.D., Medical Writing Award. His paper, titled "Survey of Influencing Factors to a Career in Family Medicine," is published here.

The award honors the memory of Frank B. Ramsey, M.D., who served as editor of *Indiana Medicine* for 41 years and was editor emeritus at the time of his death in 1993. This award will be presented annually to a student from the Indiana University School of Medicine. The editorial board of *Indiana Medicine*, in association with the dean's office at the Indiana University School of Medicine, will select an outstanding medical or scientific paper written by a student. The winning paper will be published in *Indiana Medicine*, and the author will receive \$500.

Dr. Keepes is a 1994 graduate of the Indiana University School of Medicine. □



Dr. Keepes

a SPSS/PC+ statistical analysis program. Descriptive statistics and cross-tabulations between those who have chosen a career in family practice and specific responses were generated. A p value of less than .05 was considered significant.

### Results

Of the 259 surveys mailed out, 136 were returned for a response rate of 53%. Of the 136 surveys returned, 44 (32%) of these stated a desire to enter family medicine at this time. Other popular specialty choices were obstetrics and gynecology (11%), pediatrics (10%) and general internal medicine (9%).

Section A of the survey asked the students to indicate how certain people or groups of people influenced their decision to enter family medicine. Statistical analysis showed that for those students

entering the field of family medicine, the following people or groups of people significantly influenced them toward a career in family medicine: faculty advisor (64%); department chairman in their chosen specialty (42%); residents/fellows in their chosen specialty (64%); department faculty in their chosen specialty (72%); and physicians away from the medical school that they spent time with on electives/required clerkships (82%).

Section B of the survey attempted to identify attitudes on the IU School of Medicine campus toward family medicine. It was found to be significant that departmental faculty in obstetrics and gynecology (39%) and departmental residents/fellows in psychiatry (55%) expressed a positive attitude toward family medicine as a career choice. Although not statistically significant, a high percentage of

the students that chose family medicine as a career also thought that the following people expressed positive attitudes toward family medicine: clerkship director for family medicine (82%); family medicine departmental faculty (84%); family medicine residents (69%); site director and faculty for the required third year clerkship in family medicine (86%); and the family medicine clerkship preceptor (84%). Although there were not any groups who showed a statistically significant negative attitude toward family medicine as a career choice, of those who chose family medicine as a career, 55% indicated that surgery departmental faculty expressed a negative attitude, and 61% indicated that surgery department residents and fellows likewise exhibited a negative attitude toward family medicine as a career choice.

Section C of the survey dealt

with general background information. Statistical analysis showed that men (42%) were more likely to enter family medicine than women (21%). Age, marital status, number of children, ethnic background, amount of debt after medical school, population of hometown, occupation of parents or where the first and second years of medical school were completed were not found to affect students choosing family medicine as a career.

Of the students who thought that role models played an important part in their career decision-making process, 59% stated that they were choosing family medicine as a career. This is in direct contrast with those students who stated that clinical experience played an important role in their career decision making process. Of these, 77% were entering a specialty other than family medicine.

#### Discussion

Medical students who enter family medicine are positively influenced to do so by several people. The faculty advisor, departmental chairman in family medicine, residents in family medicine, family medicine faculty and physicians away from the medical school that staff electives or required clerkships tend to have a positive influence on future family physicians. Since all of the people previously mentioned are most likely to be family physicians, our data suggest they are presenting the field of family medicine in a positive light to medical students and providing role models for students to emulate.

A review of the literature shows a paucity of studies looking at similar groups of people and their influence on a career decision. However, many studies have shown that medical schools with a required clerkship in family medicine graduate more students into family medicine residencies.<sup>6-11</sup>

Perhaps this is because these medical students are exposed to the family medicine department chairman, faculty and residents and area family practitioners and experience family medicine as it is practiced in the community. If this is the case, these data suggest the importance of the required third year clerkship in family medicine and the value of exposing medical

clerkship and clerkship preceptor. Similarly, although not statistically significant, a large percentage of students thought that the surgery faculty, residents and fellows viewed family medicine as a negative career choice.

These data bring out the following question: does the attitude expressed by other specialties on a university campus toward family medicine influence a medical student's career decision? There are no studies in the literature that have asked this question. Further research is necessary before conclusions and recommendations can be made regarding other specialties' attitudes toward family medicine on a university campus.

Our data on general background information revealed that male sex is a predisposing factor to a student entering family medicine. Many studies have shown similar

---

***Further research is necessary before conclusions and recommendations can be made regarding other specialties' attitudes toward family medicine on a university campus.***

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students to the practice of family medicine away from the medical school.

Section B of our survey revealed that family medicine is seen as a positive career choice by the departmental faculty of obstetrics and gynecology and the residents and fellows in psychiatry. Though not statistically significant, there was a large percentage of students who thought that the following people or groups of people in family medicine viewed family medicine as a positive career choice: clerkship director, departmental faculty, residents, site director and faculty for the required third-year

results.<sup>1,13,14</sup> Our study, however, failed to support previous literature that found that older aged,<sup>15,16</sup> married<sup>1</sup> students from a small hometown<sup>2,15,17-19</sup> were more likely to choose a career in family medicine. Our study did not show a significant link between age, marital status, number of children, ethnic background, amount of debt after medical school, population of hometown, or occupation of parents and choosing family medicine. The explanation for this is unclear, but perhaps it is because family medicine is appealing to a more diverse medical student population. This theory would be in line with the fact that the



number of medical students choosing family practice residencies has increased during the past two years.

The last part of our survey revealed that students who choose family medicine tend to look more for role models than those students who choose other specialties. The students who choose other specialties look more at clinical experience when making their career decision. This again indicates the importance of exposing medical students to the family medicine department chairman, faculty and residents and other family physicians practicing in the community. This is done through the required third-year clerkship in family medicine. □

Correspondence: Gary J. Keepes, M.D., 5727 Lincoln Point Blvd., Evansville, IN 47715.

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# Which type of retirement plan should you use?

**Joel M. Blau, CFP**  
**AMA Investment Advisers, L.P.**

Qualified retirement plans can be looked at as Congressionally approved tax shelters that have many major tax advantages. From the employers' standpoint, plan contributions are a deduction for income tax purposes. For the employee, earnings on the plan's investments accumulate on a tax-deferred basis. At retirement, the participants are often in a lower income tax bracket and thus pay less tax on the distributions.

There are two main types of qualified plans, which are classified as either defined benefit or defined contribution. Defined benefit plans identify or define the benefit amount each participant will receive at a given retirement age and then estimate how much must be contributed on an annual basis to provide the level of benefit at retirement. Investment rates of return and the ages of the participants have a great effect on the calculation. An actuary is used to determine the amount of the annual contribution. The employer then contributes this actuarially

determined amount, which is sufficient to pay each participant (including employer) a fixed or defined benefit at retirement. Methods of defining the benefit may be based on a flat percentage of compensation, a percentage that increases with years of service or a percentage which changes at certain compensation levels. Defined benefit plans generally favor older employees since more of the employer's contributions must go into the participant's account to make certain that there will be sufficient funds to pay the defined benefit at retirement.

Defined contribution plans generally put a percentage of current salaries into the plan each year. The amount that will be available at retirement will depend on the investment return and number of years until the participant retires. Therefore, investment results do not affect the amount to be contributed.

There are a number of different types of defined contribution plans that can be used based on the objectives of the employer. A money purchase plan requires the employer to contribute a fixed percentage of the employee's

salary each year. The size of the fund when distributions begin determines the amount the retiring participant receives. A profit sharing plan is similar to the money purchase plan, except that contributions do not need to be a specific percentage, and they do not need to be made every year. Therefore, the decision to contribute can be based on the actual profitability of a business or practice. A target benefit plan combines the elements of both the defined benefit and defined contribution plans. The annual contributions are determined as if the plan were a defined benefit plan, while the defined contribution plan annual contribution percentage and dollar amount limitations apply to the actual contributions.

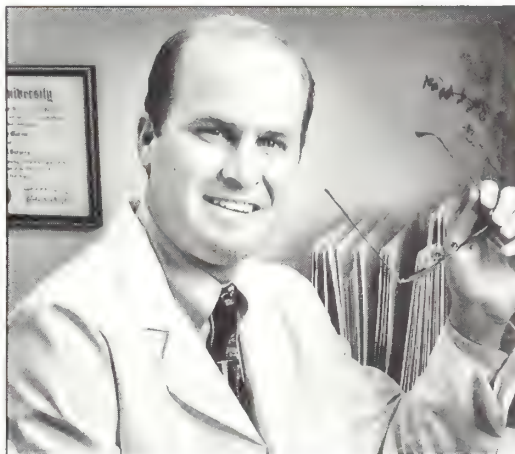
Although these are the most common plans, other variations can be used to accomplish the objectives of the employer as well as the employees. □

*Mr. Blau welcomes readers' questions. He can be reached at 1-800-262-3863.*



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# 1994 ISMA convention photo highlights



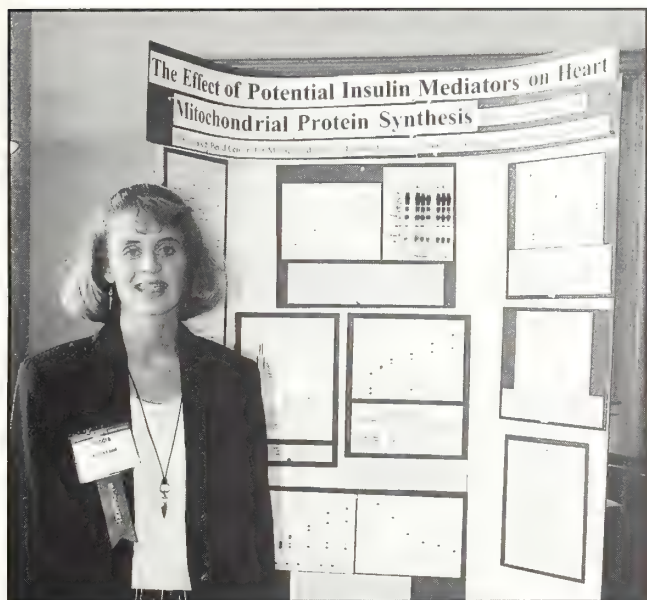
William E. Cooper, M.D., and his wife, Nancy, pose during Presidents' Night events. Dr. Cooper, a Columbus otolaryngologist, was installed as ISMA president during the convention.

Mark Lindenmeyer, M.D., Batesville, looks over the agenda during the opening session of the House of Delegates.



Michael Mastrangelo, M.D., a retired Fort Wayne general surgeon, is the winner of the 1994 Physician Community Service Award. He cares for the poor and homeless as one of the volunteer physicians at Fort Wayne's Matthew 25 Clinic where he also serves as a board member. The award is given to a physician who has served his or her community by giving time in medical and non-medical capacities.





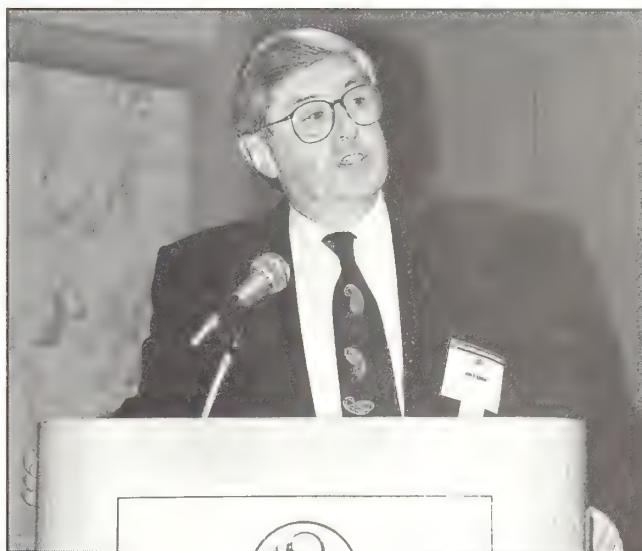
Kendra Good, a student at the South Bend Center for Medical Education, Indiana University School of Medicine, was the first-place winner in the scientific exhibit competition for medical school students.



Charles Bierbauer, left, senior Washington correspondent for CNN, talks with Alvin Haley, M.D., Indianapolis, center, and Calvin Maestro, M.D., Indianapolis. Bierbauer spoke at the annual IMPAC luncheon, focusing on the way Washington works.



Getting acquainted before the program on "Family Violence: The Physicians' Response" are Michelle Condon, M.D., a Michigan emergency room physician and domestic violence prevention advocate; William E. Cooper, M.D., center, 1994-95 ISMA president, who moderated the discussion; and Robert E. McAfee, M.D., Portland, Maine, AMA president, who spoke on the AMA commitment to domestic violence prevention.



John Iglehart, national correspondent for the *New England Journal of Medicine*, speaks during the program on "Health Care 2000: What's Ahead in Reform & Technology." Iglehart discussed health system reform and forecast what's ahead.



Richard Huber, M.D., Bedford, speaks at a reference committee hearing.



Sen. Patricia Miller, R-Indianapolis, addresses the semi-annual meeting of the Indiana Roentgen Society. The state legislator explained the importance of participating in the legislative process.



William E. Cooper, M.D., of Columbus, left, is the newly installed ISMA president, and William VanNess II, M.D., Summitville, is the immediate past president.



Thomas Whiteman, M.D., Muncie, left, listens as exhibitor Shawn Whelan of Health Care Communications explains his company's products.





Members of Reference Committee 2 are, from left, James Reidy, M.D., Mishawaka; John Slack, M.D., Indianapolis; Lana Patch, M.D., chairman, Huntington; Charles Dinwiddie, M.D., Muncie; and Barbara Bourland, M.D., Lafayette.



Edward White, D.O., Princeton, stops in the exhibit hall to talk with Glenna Braley, R.R.T., left, and Cheri West, R.N., both of whom represented THC Indianapolis.



Ronald Rice, M.D., Indianapolis, and his wife, Marcia, were among the 220 people who attended the Presidents' Night dinner and dance.

# 1994 ISMA convention coverage

## **Call to order, miscellaneous business**

The Indiana State Medical Association House of Delegates convened its 145th Annual Convention at 9 a.m., EST, Friday, Oct. 21, 1994, at the Westin Hotel in Indianapolis. The final session of the House of Delegates convened at 9 a.m., EST, Sunday, Oct. 23, 1994.

Presiding at both sessions was Peter Winters, M.D., speaker, Indianapolis, assisted by John Thomas, M.D., vice speaker, Fort Wayne. Larry Allen, M.D., served as parliamentarian. Allen Rumble, pastor of the Zionsville United Methodist Church, presented the invocation.

## **Approval of minutes**

The proceedings of the 144th Annual Meeting of the House of Delegates, Indiana State Medical Association, conducted Oct. 15-17, 1993, at the Westin Hotel, Indianapolis, and published in the January/February 1994 issue of *Indiana Medicine*, were approved.

## **Addresses/reports**

The addresses of the president, president-elect and president of the ISMA Alliance (all referred to Reference Committee 1) were filed with commendation.

All reports (printed in the September/October 1994 issue of *Indiana Medicine*) were filed, with the exception of the treasurer's report, which is referred for audit.

## **Election of officers**

William E. Cooper, M.D., Columbus, president-elect, succeeded to the office of the president. Jerome Melchior, M.D., Vincennes, was

elected president-elect. Other elections included:

Treasurer – Timothy Brown, M.D., Crawfordsville

Assistant treasurer – Frank Sturdevant, M.D., Valparaiso

Speaker of the House – Peter Winters, M.D., Indianapolis

Vice speaker of the House – John Thomas, M.D., Fort Wayne

Chairman, Board of Trustees – Alfred Cox, M.D., South Bend

At large members, Executive Committee – Stephen Tharp, M.D., Frankfort; Barney Maynard, M.D., Evansville

## **Election of delegates, alternate delegates to the AMA**

The following were elected to two-year terms to the American Medical Association (terms expire Dec. 31, 1996).

### **Delegates:**

John Knot, M.D., Lafayette  
Shirley Khalouf, M.D., Marion  
William Beeson, M.D., Indianapolis

### **Alternates:**

Max Hoffman, M.D., Covington  
C. Dyke Egnatz, M.D., Schererville  
Alfred Cox, M.D., South Bend

Paula Hall, M.D., Mooresville, was elected to a one-year term as an alternate delegate, filling an unexpired term. Her term expires Dec. 31, 1995.

Holdover AMA delegates and alternate delegates (terms expire Dec. 31, 1995) are:

### **Delegates:**

John MacDougall, M.D., Indianapolis

Marvin Priddy, M.D., Fort Wayne  
Michael Mellinger, M.D., LaGrange

### **Alternates:**

George Rawls, M.D., Indianapolis  
Barney Maynard, M.D., Evansville

## **Trustees/Alternates, 1994-1995**

The House of Delegates confirmed the newly elected/re-elected trustees and alternates for 1994-1995.

### **Trustees:**

District 1 – Barney Maynard, M.D., Evansville  
District 2 – James Beck, M.D., Bloomington  
District 3 – John Seward, M.D., Bedford  
District 4 – Arthur Jay, M.D., Lawrenceburg  
District 5 – Fred Haggerty, M.D., Greencastle  
District 6 – Ray Haas, M.D., Greenfield  
District 7 – Ron Stegemoller, M.D., Danville  
District 7 – John Records, M.D., Franklin  
District 7 – Bernard Emkes, M.D., Indianapolis  
District 8 – John Osborne, M.D., Muncie  
District 9 – Stephen Tharp, M.D., Frankfort  
District 10 – Thomas Brubaker, M.D., Griffith  
District 11 – Laurence Musselman, M.D., Marion  
District 12 – Joseph Manthey, M.D., Liberty Center  
District 13 – Alfred Cox, M.D., South Bend  
Resident Medical Society – Ruchir Sehra, M.D., Indianapolis



Medical Student Section – Mike  
Hardacre, Noblesville

**Alternate trustees:**

District 1 – Bruce Romick, M.D.,  
Evansville  
District 2 – Gene Bourgasser, M.D.,  
Sullivan  
District 3 – Daniel Cannon, M.D.,  
New Albany  
District 4 – Lawrence R. Bailey,  
M.D., Aurora  
District 5 – Fred Drake, M.D., Terre  
Haute  
District 6 – Howard Deitsch, M.D.,

Richmond  
District 7 – Frank Johnson, M.D.,  
Indianapolis  
District 7 – Paula Hall, M.D.,  
Mooresville  
District 7 – Girdhar Ahuja, M.D.,  
Indianapolis  
District 8 – Susan Pyle, M.D.,  
Union City  
District 9 – Daniel Berner, M.D.,  
Lafayette  
District 10 – John Swarner, M.D.,  
Valparaiso  
District 11 – Regino Urgena, M.D.,  
Marion

District 12 – Scott Wagner, M.D.,  
Fort Wayne  
District 13 – Richard Houck, M.D.,  
Michigan City  
Resident Medical Society – Trent  
Miller, M.D., Indianapolis  
Medical Student Section – Beth  
Ellis, Indianapolis

**Future meetings**

1995 ..... Oct. 20-22  
Radisson Hotel  
1996 ..... Oct. 18-20  
Westin Hotel □

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## In memoriam

**T**he ISMA pays tribute to its members who have died since the 1993 session:

Joseph E. Ball, M.D., Indianapolis  
Milton Bankoff, M.D., Michigan City  
Max D. Bartley, M.D., Indianapolis  
Robert Barton, M.D., Angola  
Neal E. Baxter, M.D., Bloomington  
Frank J. Brakel, M.D., Evansville  
Robert Brown, M.D., Leesburg  
Edward Campagna, M.D., San Carlos,  
Calif.  
Joe H. Carr, M.D., Henryville, Ill.  
Charles Cooney, M.D., Fort Wayne  
James Cortese, M.D., Indianapolis  
Dale Dickson, M.D., Greensburg  
Thomas Dittmer, M.D., Valparaiso  
William Douglas, M.D., Indianapolis  
H. Carter Dunstone, M.D.,  
Angel, N.M.  
James C. Farr, M.D., Bloomington  
James Fitzpatrick, M.D., Portland  
Arturo Florcruz, M.D., Highland

Clementine Frankowski, M.D.,  
Whiting  
Max Ganz, M.D., Marion  
Robert Garrett, M.D., Indianapolis  
Roy A. Geider, M.D., Ann Arbor,  
Mich.  
Meredith Gossard, M.D., Tipton  
John Greist, M.D., Indianapolis  
Richard Griffith, M.D., Indianapolis  
Stephen Hermayer, M.D., Evansville  
Phillip Hodonos, M.D., Michigan City  
Lillian Holdeman, M.D.,  
Edwardsburg, Mich.  
James Katterjohn, M.D., Indianapolis  
H. Kim, M.D., Kokomo  
Francis Kubik, M.D., Michigan City  
Forrest LaFollette, M.D., Munster  
John F. Ling, M.D., Richmond  
Harold Lynch, M.D., Bloomington  
Robert McElroy, M.D., Princeton  
Jack Mershon, M.D., Monrovia  
George Morrison, M.D., Lawrenceburg  
Ottis N. Olvey, M.D., Indianapolis  
Eddie Pappas, M.D., Merrillville  
Richard Purcell, M.D., Griffith

Harold D. Pyle, M.D., Sun City, Ariz.  
Ben B. Raney, M.D., Linton  
Vivencio Raymundo, M.D., Elwood  
William Renforth, M.D., Connersville  
Walter Repay, M.D., Hammond  
George Reul, M.D., Kokomo  
Charles Rutherford, M.D., Lafayette  
Jaime Salomon, M.D., Indianapolis  
Alvin Schaaf, M.D., Crawfordsville  
John Schreiner, M.D., Bremen  
Charles Seaman, M.D., Frankfort  
Lyle Siegel, M.D., Evansville  
Elsworth Stucky, M.D., Indianapolis  
Joseph Teegarden, M.D., Chicago, Ill.  
Noshir Toddywalla, M.D., Cincinnati,  
Ohio  
Daniel Tweedall, M.D., Evansville  
Robert Warren, M.D., Richmond  
Bryce P. Weldy, M.D., Hartford City  
Abram Woodard, M.D., Indianapolis  
J. William Wright, M.D., Indianapolis  
Robert J. Yingling, M.D., Clearwater,  
Fla.  
Robert C. Ziss, M.D., Evansville □

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## William E. Cooper, M.D., installed as ISMA president

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**W**illiam E. Cooper, M.D., a Columbus otolaryngologist, was sworn in as president of the ISMA Oct. 23 during its 145th annual meeting in Indianapolis.

He has held the following positions with the ISMA: president-elect, speaker of the House of Delegates, chairman of the board of trustees and Fourth District trustee and alternate trustee.

A 1966 graduate of the Indiana University School of Medicine, Dr.

Cooper is certified by the American Board of Otolaryngology and is a fellow of the American College of Surgeons. He is a member of the American Academy of Otolaryngology-Head and Neck Surgery and has served as president of the Indiana Academy of Otolaryngology-Head and Neck Surgery.

He is on the staff of Columbus Regional Hospital, where he has served on many committees. □



Dr. Cooper

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## Jerome Melchior, M.D., chosen ISMA president-elect

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Dr. Melchior

**J**erome E. Melchior, M.D., a Vincennes urologist, was chosen president-elect of the Indiana State Medical Association during its annual convention. He has served as chairman of the ISMA board of trustees for the past two years.

He is a staff member at Good Samaritan Hospital in Vincennes, where he has been president of the medical staff, chairman of the hospital utilization committee and

chairman of surgery service. He is certified by the American Board of Urology and is a fellow of the American College of Surgeons and a member of the American Urology Association. He serves on the American College of Surgeons Committee of Applicants for Southern Indiana.

A native of Topeka, Kan., Dr. Melchior is a 1967 graduate of the University of Kansas School of Medicine. □



## Address of the president-elect, William E. Cooper, M.D.

**M**r. Speaker, officers, trustees, delegates, guests ... I am honored for the privilege to serve the Indiana State Medical Association as its 152nd president. The responsibility is awesome; the honor, humbling. I pledge to do my best to maintain the stewardship of the ISMA.

It occurs to me that one could compare the last several years in the practice of medicine to white water rafting. It seems just as we've crested the rapids, more wait around the next bend. And they are rougher, more turbulent and more threatening.

The ride's not over yet, and I'm sure some of us feel as if we've lost our paddles.

The changes we see, whether prompted by government or market forces are like rocks jutting up from a river bottom. They threaten to dislodge us from our raft, if not totally capsize us. By the same token, they give us a chance to test our mettle.

A successful white water raft crew uses teamwork to navigate the rocks and rapids, and so must we. It is of grave concern to me how much disunity we have witnessed in organized medicine.

Already we have seen certain medical specialties "jump ship." That fact plays into the hands of those who wish to reduce the influence doctors have in our health care system. And, it confuses the public about what role physicians should play.

The media capitalize on the differences among us, thus fanning the flames of disunity as we try to stay afloat and maintain our

course.

As the river becomes rougher, some of us respond by seeking other routes around the rapids.

Others vow to stay in the raft and hold on to the old ways until finally hitting an obstacle or running aground.

What I hope we physicians will do is re-unify our crew. It has taken all of us, primary care and specialists alike, to make this the finest health care system in the world. We must unify behind our common goal to provide quality care for our patients.

Just how the course of the river is changing is uncertain, but it is changing ... if not at the rate we first anticipated. Some still question if we will have real health system reform.

To paraphrase Mark Twain, "The rumor that health system reform is dead is greatly exaggerated."

There will be no reform from Congress this year. From the standpoint of practicing physicians, we still need to be concerned.

Will Congress act on incremental reforms next year? Quite possibly. If so, we need to make certain that those reforms do not preempt laws that have worked in Indiana to protect access to quality care in our state.

Laws like INCAP, the Indiana Compensation Act for Patients, and our any willing provider law.

There are reforms that should be enacted to accommodate market forces now underway in the health care delivery system. The Patient Protection Act and antitrust protections, for example,

More than 80 percent of Americans want the ability to see their own physicians even if that means paying more.

We need to push for patient protection to ensure health care decisions are made by patients and their physicians, not insurance clerks.

Patients must be told of exclusions in the insurance coverage, prior authorizations necessary for care and any financial arrangements that would limit services. These are real problems happening every day that need to be addressed soon.

More adjustments are needed to the enforcement policy on antitrust and health care recently released by the Federal Trade Commission.

The statements do not go far enough and leave physician networks at a serious disadvantage to non-physician networks. This problem must be rectified.

Next year, both in the Congress and in the state legislature, the door is open for single payer advocates to come back with a vengeance. Incidentally, next year is not an election year. The prospect that an unpopular health reform law could stymie either political party's re-election efforts will not be a factor in 1995 as it was this year.

But if elections are not a factor, the federal deficit will be. Congress next year must consider dire predictions about the federal deficit.

According to *Medicine & Health*, Medicare expenditures are expected to rise from \$158 billion in 1994 to \$290 billion by 2000.

Medicaid expenditures will increase even more from \$150 billion in 1994 to \$295 billion by 2000. The two make up the largest component of the deficit.

Political observers agree that there will be new players when the 104th Congress convenes. Republicans are likely to win 20 to 35 seats in the House and four to six in the Senate. If that's the case, we can anticipate a more conservative Congress.

And even if those seeking reelection are successful, many important health care voices will be missing when Congress reconvenes; either because of voluntary retirements or primary election losses.

Sen. George Mitchell, Rep. Bob Michel, Rep. Mike Synar, Sen. Howard Metzenbaum and many others will be conspicuous in their absence.

Whatever Congress does, public opinion will play a role. Nearly three-quarters of Americans still think our health system is in a "crisis." Sixty-eight percent said they would be disappointed if Congress did not pass a health care bill in the next year.

Closer to home, an *Indianapolis Star*/WISH-TV survey indicated 35% of those polled said health care was the number one issue they wanted candidates to talk about.

So what can we expect in the Indiana General Assembly? Look for a single-payer bill. A single-payer bill has been introduced every year since 1990. Although it has never received a hearing in the Indiana Senate, it passed the House last year. We can expect another try in the upcoming session. Look for legislation on insurance reform and legislation

for medical savings accounts.

As you know, the members of this House of Delegates passed a health system reform proposal just last year that would incorporate insurance reform and medical savings accounts. The proposal has been distributed to Indiana legislators and has been the subject of several media interviews.

Obviously, communications will continue to be important as we move into next year. Not just among our members, but between the ISMA and the various other publics.

The ISMA has conducted meetings with other health care providers and business groups to determine if some kind of consensus health system reform bill might be introduced in the legislature.

This past summer, the ISMA government relations staff met with Indiana legislators to look ahead at a legislative agenda.

In a new event, something we have not done before, the ISMA will conduct a "Health Care Institute" involving legislators from each caucus in the Indiana General Assembly in the weeks following the election.

Experts on health topics will meet with designated members from each caucus to provide information on some fundamental health issues – topics like the Patient Protection Act and antitrust.

The Health Care Institute will be held one day a week from mid-November to the first week in December. On the fourth and final day of the institute, participants will spend a day on the job with a physician – either primary care or specialist.

This Health Care Institute for

state legislators is similar to one conducted last summer for congressional health legislative liaisons.

Our congressional efforts continued with an early fall Washington visit with the ISMA leadership meeting with Congressmen or health staffers in all 12 Indiana congressional offices.

It is our hope that our continued contacts with our congressional delegation and their health assistants will result in more co-sponsorships of legislation we support.

The Communications Department has set up media training for ISMA members and leaders and followed up the training with scheduled visits in small and medium-sized media markets in the state.

During those visits, we've discussed the ISMA health system reform plan, the Patient Protection Act, antitrust and the any willing provider issue.

One question we always get is, "What is the ISMA?"

Outside of Indianapolis, we are not particularly well-known. And we want to change that.

Why? Because we have a responsibility as patient advocates to let the public know that members of the Indiana State Medical Association care about their health and safety.

If the public doesn't know who we are and that we support the goals of universal access, cost containment, quality and freedom of choice in health care, we cannot call upon them to help us achieve these goals.

We also want to position the ISMA as a credible source of medical and health related information.



Earlier this year, a consortium was formed to study how the AMA, state and county medical societies can prepare to meet the needs of physicians in the 21st century.

The consortium's research indicates that physicians will need (quote) "greater public trust and credibility and an improved image as advocates of patients." To meet these goals, we need visibility with media both inside and outside of Indianapolis.

Our media visits will continue next year as we take our message into the larger media markets. So expect to see us in Evansville, Fort Wayne, South Bend, Gary and Louisville.

For our members, the ISMA will continue to provide up-to-date information through our publications, *ISMA Reports*, *Indiana Medicine* and the *Medicare Committee Report*.

In the area of practice management, the ISMA has added new programming reflecting the changing needs of our members.

Not only did we offer a seminar on managed care and physician hospital organizations this year, but we are following up with a seminar on physician organizations on Nov. 2.

The PHO study completed earlier this year in partnership with the AMA and the Michigan and Illinois state medical societies

will be followed by a study of physician organizations that will be published in 1995. Our efforts to collaborate with other state medical societies have increased our ability to provide you with timely information.

During the past few minutes, I have expressed to you my concerns about the disunity among physicians, my impressions about health system reform and some thoughts on what we might see legislatively next year.

I've talked about the importance of communications in positioning the ISMA as an advocate both for our members and our patients.

There is one other topic I want to address. This year, as president-elect, I had the responsibility of chairing the ISMA/ISMA Alliance Task Force on Family Violence that was established by our president, Dr. William VanNess.

Little did we know when we started our effort to alert physicians to the problem of family and domestic violence that the issue would be prominently displayed almost daily in the news.

Unfortunately, the coverage largely has failed to focus on the victimized. When you realize that family violence strikes one in four American families, you know that some of your patients have to be among those who are affected.

This task force has worked

diligently to develop a program to assist you in identifying and responding to patients who request assistance with family violence issues.

The task force's goal also has been to provide you with access to educational resources and local referral resources so you can better serve your patients.

I'll leave the details to the experts who will present Saturday afternoon's panel discussion, but I urge you to attend the program and to visit the task force's booth in the exhibit hall.

It's easy to want to avoid contemplating such a disturbing societal problem, but as physicians ... as healers, we carry a certain responsibility to provide leadership. Indeed, AMA research shows that 80% of Americans feel they could tell a physician if they had either been a victim or perpetrator of family violence.

We are in a position to make a difference in reducing and preventing family and domestic abuse.

In closing, as we look forward to what faces us in this river of change, we can fear the rocks and rapids or we can unify through our membership in the Indiana State Medical Association and use our combined strength to chart a new course. I sincerely hope we will follow the latter alternative.

Thank you. □

## Address of the ISMA Alliance president, Sue Ellen Greenlee

Good morning.

It is quite an honor to be escorted up here to the head table by ISMA's Director of Government Relations Mike Abrams. That is a treat that Alliance presidents look forward to each year. I have been fortunate to have received this honor twice. That's right! I was here last year. The distinction of being an 18-month president, so I was told by Dr. Mellinger, puts me in the history books with Dr. Popplewell, who was ISMA president for two years, 1979-80.

I hope everyone knows by now, that our name is alliance. Auxiliary is a term that is quickly become outdated. All of our counties have changed their local names to alliance.

If you recall, and I seriously doubt it, but last year my speech contained three words, which I repeated a lot.

Active, alive and aware. Your medical alliance is very active, very alive and very aware. But at times this year, I could say, it has also been aggravating, annoying and addictive. But the time has come for me to abdicate my position and let the next president begin her term of office.

My final duty is to fill you in about what our Alliance year has accomplished. I can use three words again.

Achievements. Affirmations. Acknowledgments. These are my three words for the summary of our 1993-94 year.

### Achievements

The total restructure of our organization has been achieved. We have

now a new logo, extensively revised bylaws, a new fiscal year, a new president's pin, a revised format for our annual convention, revised our publication, *The Alliance Alert*, which goes to each member, and created a newsletter that goes out each six weeks to county presidents and presidents-elect. We have used conference calls for committee meetings to save money and time. We made our budget stretch from the usual 12 months to 18 months – and stretch it did! With our minimal dues of just \$18, that is really an achievement.

We held leadership workshops in three areas of the state, so we could be more accessible to our county leaders. We attended and were on the agendas at the business meetings of all 13 ISMA district meetings throughout the state – for the second year in a row.

I believe that the physicians now recognize the purpose of the alliance and realize that the alliance, physicians' spouses, are out in their communities doing projects for health, fundraisers for worthwhile medical causes, working on legislative activities and helping create positive rapport for the medical community.

On behalf of the ISMA and the alliance, I have spoken to Rotarians, councils on aging and the Kiwanis about health system reform. So have other alliance members. We're creating a good public image for you and medicine.

We, jointly with you, held a successful Marriage Enrichment Weekend Workshop last February

– held during a snowstorm that kept only three couples away who had pre-registered. Everyone else showed up. That tells me the importance and the interest in the necessity to address the stresses and needs of medical families.

### Affirmation

Affirmation is in seeing the resolutions regarding abuse, which were proposed last year, move forward and gain ground. That is very satisfying and positive. Acknowledging the extent of child abuse and spousal abuse by putting such statements on birth certificates and marriage licenses is the purpose of these two resolutions.

The panel on family violence, with national speakers, being held here tomorrow afternoon is another affirmation of the importance of our project and that there is still so much more educating to be done regarding this facet of a physician's practice.

Another achievement is that Indiana University presented an award, a commemorative medalion that is displayed in the lobby, to the national AMA-ERF headquarters in Chicago in recognition of raising more than \$250,000 for the medical school in Indiana. Your spouses raised three times that amount of money that you, as physicians, donate to the medical school. Today, outside the lobby, we are holding a statewide fundraiser – a silent auction – of different holiday centerpieces. Please support this effort. Simply sign your name on a sheet stating your bid. All money is tax-deductible and goes through the AMA-



ERF to the IU School of Medicine. It helps the doctors of tomorrow.

### Acknowledgment

While we acknowledge and take pride in what we have done and what we are doing, we must also acknowledge that there are areas that still need work, mainly membership. Last year, we had 2,040 members. This year, we lost 99 members. Eight years ago, our total was more than 2,700 members.

Why the declining membership? This serious issue is a concern for both of us, and it must be acknowledged.

Is the reason for the decline the changing times? The changing medical climate? Or lack of commitment? Do we need to re-evaluate the purpose or need for our organizations to make us more compatible with today's lifestyles? With more and more physicians becoming employees, how much interest will physicians have in joining a medical society?

As for your spouses, do they have an interest in joining the

alliance? With our lifestyles today, with more employed spouses and with everyone's time being sought after by every group in town, people will join and be active in a group only if they believe in it! If they value its focus and if they know that there is a benefit to them personally if they are a member. Let's work on membership together. Our alliance brochure, called the *ISMA-A Prospectus*, is in your packet. Please look it over and note the great positive benefits available. Please give it to your spouse, and find out if he/she belongs. We want and need every ISMA member's spouse to join us.

I would be very remiss if I did not publicly acknowledge and thank you, the physicians, for your support, as well as thank the ISMA. We have a powerful partnership with you, and it is strengthening constantly. The vibrant leadership of the ISMA is fun to watch, great to learn from and a pleasure to work with. Drs. VanNess, Beeson, Cooper and Melchior are men who are devoted

to and give so much to the members of this organization. Thank you very much.

The staff at headquarters is excellent, very accommodating and give the alliance leaders professional guidance. They have helped the alliance grow. I've enjoyed getting to know you, the staff and working with you all this past year. Thank you very much.

Will all the county medical alliance presidents please stand? Would all of you join me in acknowledging these leaders who work for you physicians in your home areas?

Well, that's your ISMA Alliance for 1994.

Active, alert and aware – with its many achievements, affirmations and acknowledgments.

Please keep supporting us and our activities.

We're talented people, like you; volunteers, like you, who serve so well, and we are all dedicated to the health of the citizens of Indiana.

Thank you. □

## Scientific exhibit winners

### First place

#### **"Regulation of mitochondrial protein synthesis by second messengers in the rat heart"**

Exhibitors: Kendra S. Good, South Bend Center for Medical Education, Department of Biochemistry and Molecular Biology, Indiana University School of Medicine, and Department of Chemistry/Biochemistry, Notre Dame, Ind.

The biogenesis of the mitochondrial inner membrane requires the coordination of two genomic systems: the nuclear cytoplasmic system, responsible for the majority of inner membrane proteins, and the mitochondrial system, responsible for 13 essential peptides of four inner membrane enzyme complexes. Hormones and second messengers such as cyclic-AMP and  $Ca^{++}$  have been shown to be important regulators of nuclear-cytoplasmic gene expression; however, the effects of these hormones and second messengers on processes of biogenesis within the mitochondrial compartment are largely unknown. In the present work, the effects of  $Ca^{++}$  and two presumptive second messengers of insulin action (pH 1.3 and pH 2.0 inositol-phospho-glycan mediators) were investigated with regard to their effects on mitochondrial protein synthesis. This was accomplished by following the incorporation of [35S]-methionine into protein in a well-characterized *in vitro* system utilizing intact rat heart mitochondria. Levels of free  $Ca^{++}$  (regulated using Ca-EGTA buffers) below

0.5 $\mu$ M did not alter the rate of protein synthesis, while levels above 1 $\mu$ M inhibited rates of protein synthesis. Analysis of the labeled translation products by SDS-PAGE and autoradiography suggested that the change in synthesis rates was general and affected all products. The pH 1.3 inositol-phospho-glycan mediator completely inhibited mitochondrial translation at concentrations  $\geq .05$ mM. This mediator is known to completely inhibit cAMP-dependent protein kinase as well as other kinases in metabolic pathways, and the addition of 50 $\mu$ M cAMP or dibutyl cAMP did not alter the inhibition of mitochondrial translation. The pH 2 inositol-phospho-glycan mediator stimulated the rate of protein synthesis in mitochondria from rat hearts that had been perfused without insulin for three hours by 117%. ▽

### Second place

#### **"Efficacy of four surgical procedures for the treatment of short bowel syndrome"**

Exhibitors: Eugene Lin, Department of Surgery, Section of Pediatric Surgery, Indiana University School of Medicine.

Short bowel syndrome (SBS) is a significant cause of morbidity and mortality in infants and adults with necrotizing enterocolitis, atresia, volvulus or vascular accidents. There is no satisfactory surgical treatment at the present time. The purpose of this experiment was to determine the efficacy

of four surgical procedures in improving absorption and increasing survival in rats with the short bowel syndrome.

Ninety-one Sprague-Dawley rats weighing 180-220 grams were divided into five groups to receive: Group I (n=12), 70% distal small bowel resection (SBR); Group II (n=20), 70% SBR with a 2 cm small bowel reversed segment; Group III (n=20), 70% SBR with isoperistaltic colonic interposition; Group IV (n=19), 70% SBR with formation of a recirculating loop; and Group V (n=20) 70% SBR with formation of a new ileocecal valve. Measured parameters included survival rate, weight, serum albumin, cholesterol, triglycerides, prealbumin and transferrin. Survival at eight weeks was Gp I 100%, Gp II 45%, Gp III 55%, Gp IV 5%, and Gp V 40%, with nearly all deaths occurring within the first two weeks.

The mean weight gain determined as a percent of the preoperative weight when compared with group I was Gp, II 18% ( $p<.5$ ); Gp III, 36% ( $p<.001$ ); and Gp V, 11% ( $p>.2$ ). Use of the two sample student's t test yields the following P values for the differences in the albumin (g/dL), triglyceride (mg/dL), and cholesterol levels (mg/dL) in a comparison of groups II, III and V, with group I. Gp II: 2.5 ( $p<.01$ ), 84 ( $p<.1$ ), 77 ( $p<.02$ ); Gp III: 2.0 ( $p<.05$ ), 52 ( $p<.5$ ), 68 ( $p<.01$ ); Gp V: 2.6 ( $p<.001$ ), 129 ( $p<.01$ ), 98 ( $p<.01$ ). The Bonferroni method considers  $p<.0125$  as significant because of the multiple comparisons.

In conclusion, a 70% SBR alone did not result in any mortality. The



decline in serum albumin levels noted in Group I was prevented by procedures II and IV. In addition, there was a significant elevation of serum triglycerides and cholesterol in Group V. Despite the mortality associated with these procedures, the valve and reversed segments may be viable clinical therapeutic options. □

### Third place

#### **"Ophthalmic arterial hemodynamics during isometric exercise"**

**Exhibitors: Dennis J. Beck, Indiana University School of Medicine, Indianapolis.**

Isometric exercise raises systemic arterial pressure and, simultaneously, lowers intraocular pressure (IOP). Together, these pressor effects increase calculated ocular perfusion pressure and test the capacity for flow and pressure autoregulation in the orbital circulation. We believe that

patients with normo-tensive (IOP < 22 mmHg) glaucoma lack adequate perfusion to the optic nerve and retinal nerve fiber layers, which results in chronic degeneration and loss of function. This may be due to the lack of ability of these patients to autoregulate ocular blood flow. Normal endpoints of hemodynamic autoregulation must be established before patients can be evaluated.

We investigated, in 17 young healthy subjects, the effect of isometric exercise on ophthalmic arterial hemodynamics, as measured by color Doppler imaging. Isometric handgrip exercise (10 min. at 20% maximal force) predictably raised systolic ( $114 \pm 2$  to  $122 \pm 3$  mmHg;  $p < 0.01$ ), diastolic ( $69 \pm 2$  to  $78 \pm 2$  mmHg;  $p < 0.01$ ) and mean systemic pressure ( $84 \pm 2$  to  $93 \pm 3$  mmHg;  $p < 0.01$ ). Because exercise also reduced intraocular pressure (from  $14.2 \pm 0.5$  to  $12.2 \pm 0.4$  mmHg,  $p < 0.01$ ), calculated ocular perfusion

pressure rose from  $42 \pm 3$  mmHg before exercise to  $50 \pm 3$  mmHg during exercise ( $p < 0.01$ ). Despite this pressure rise, we found no evidence for exercise-induced vasoconstriction in the ophthalmic artery; peak systolic velocity (PSV) was unaltered by exercise, while end-diastolic velocity (EDV) rose (from  $5.8 \pm 0.5$  cm/sec at rest to  $8.4 \pm 1.3$  cm/sec during exercise;  $p < 0.01$ ). These velocity changes reduced the calculated resistance index ((PSV-EDV)/PSV) from  $0.82 \pm 0.01$  at rest to  $0.78 \pm 0.02$  during exercise ( $p < 0.05$ ).

We conclude that isometric exercise-induced increases in ocular perfusion pressure are apparently associated with reductions in vascular resistance distal to the ophthalmic artery, a result suggesting that ocular blood flow or microvascular pressures may not be autoregulated under these conditions. This may establish normal endpoints to which individuals with low-tension glaucoma may be compared. □

## ■ annual reports

*Editor's note: These annual reports were not submitted in time to be included in the September/October 1994 issue of Indiana Medicine.*

### **MEDICAL STUDENT SOCIETY** **Michael Hardacre, trustee**

Serving as trustee representing the Medical Student Society has been an honor and a privilege throughout the year. As usual, it has been a busy and productive year for the student section.

Once again, we had strong representation at the interim and annual meetings. At the interim meeting this year, one of our student delegates, John Oester, was recognized by Glaxo with a National Leadership Scholarship for his involvement at all levels of the American Medical Association. This was one of only 25 such awards given throughout the entire Medical Student Section. We also were able to send a very motivated group of students to the National Leadership Conference. Recruitment, one of our main goals for the year, went extremely well this year with Indiana University, via Beth Ellis, receiving an Outreach Recruitment Award with certain campuses having as high as 90% recruitment rate.

Thanks to the ISMA's continued support in allowing students to sit on various committees, an area of deficit was recognized within the student section. Until now, if a medical student was thought to have a substance abuse problem, even if this was a self-motivated search for help, the only avenue available was to contact the dean's office, which is obligated by law to include knowledge of this problem in the student's dean's letter, which presents

obvious long-term consequences. The student representatives to COPA recognized this problem and, with the help of the ISMA and COPA, established the Committee on Medical Student Assistance (COMSA), giving students the avenue for help and support without the sequelae. This issue also prompted two of our members, Madeline Eversoll and Angela Stevens, to write a resolution on AMA-MSS support of similar committees nationwide, which was discussed at A-94 and will be introduced at I-95.

This past year, the Student-to-Student program continued to have increasing support and success. The northwest, Terre Haute and Bloomington campuses all have very active programs, with Lafayette and Fort Wayne soon to be included. This program sends medical students to primary and secondary schools to speak about health-related issues such as smoking, drugs, alcohol, AIDS, etc. This year, Terre Haute took the program one step further, teaching high school students self breast and testicular exams. Next year, we hope to build even further upon this program due to the great response we have received.

On behalf of myself and the entire Medical Student Society, I thank the ISMA for its continued support. We also extend a special thanks to Rosanna Iler for her continued help, not only within the Medical Student Society but also for providing a life-line to the ISMA.

### **THIRD DISTRICT** **Gordon L. Gutmann, M.D., trustee**

This marks the final year of my

two terms as trustee of the Third District. It has been a most enlightening and worthwhile experience. I want to thank all of those concerned with the ISMA, especially our field representative, Janna Kosinski, for the excellent work she has done for the district.

The physicians throughout my district have their eyes on the government's plans for health care reform. Even if nothing comes out of Congress, the insurance companies continue to propose changes to modify the way we must practice. Changes in the antitrust legislation will be necessary if we are ever to band together to present a unified front against these changes. In our area, a lot of our focus comes from Louisville and Humana/Columbia Health Care Systems. It seems that every area has its own set of problems.

Good luck to John Seward, M.D., the new trustee.

### **FIFTH DISTRICT** **Fred Haggerty, M.D., trustee**

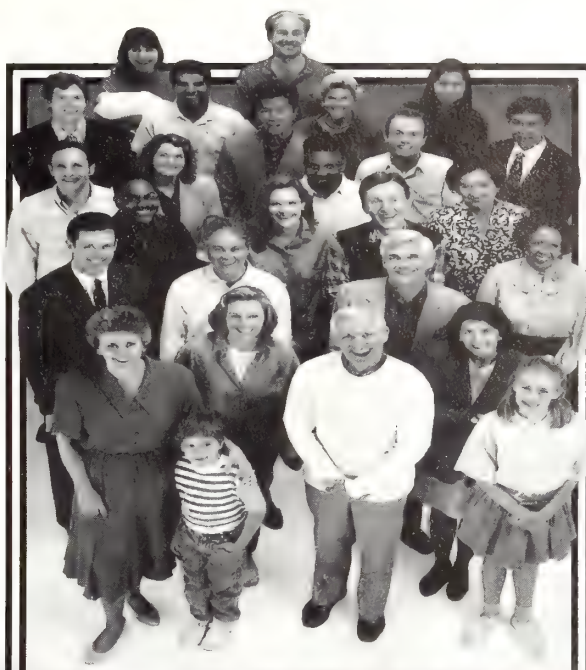
Another year has slipped by us. The turmoil of health system reform has occupied most of our attention. We have held productive quarterly meetings in various areas of the district.

The annual meeting was held May 19 in Terre Haute, and the AMA immediate past president spoke on "The AMA's Role in Health Care Reform." Next year's annual meeting will be held in Greencastle, probably at the Walden Inn. The atmosphere will be relaxed.

I want to thank Janna Kosinski, ISMA field representative, for her attention to all areas of the district this year. □



Our annual reunion demonstrates what makes The James so special - our dedication to caring for your patients. You see, The Arthur G. James Cancer Hospital and Research Institute has a focused mission. To help people who have cancer and their families. So if you ever need to refer a cancer patient, you can be sure our primary interest is their good care.



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There are many reasons The James is so special. Here are just a few. But every year at our reunion, there are about 1,200 more.



*The Arthur G. James Cancer Hospital and Research Institute, Columbus, Ohio*

# THE JAMES

THE NEXT GENERATION OF HOPE

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## ■ resolutions

### **RESOLUTION 94-1      AMA Delegate Election Procedure**

Introduced by: William W. Pond, M.D., Fort Wayne  
 Referred to: Reference Committee 1  
 Action: Not adopted

Whereas the Indiana State Medical Association selects three delegates to the AMA House of Delegates each year; and

Whereas these delegates are selected at large; and

Whereas the American Medical Association election procedures require electors to utilize all the votes that are permitted for at large positions; and

Whereas the procedure utilized by the American Medical Association is a more equitable method of election because it precludes "cumulative voting" and "bullet balloting;" and

Whereas the ISMA Bylaws do not address the voting method for delegates to the AMA; and

Whereas a uniform method of election is in the best interest of the Indiana State Medical Association; therefore be it

RESOLVED, That the Bylaws of the Indiana State Medical Association be amended so as to contain a provision that requires the ISMA election procedure for AMA Delegates to be the same as that used by the AMA.

### **RESOLUTION 94-2      Including Gram Stain in a Physician's Armamentarium**

Introduced by: Bernard J. Emkes, M.D.  
 Referred to: Reference Committee 1  
 Action: Adopted

Whereas, gram stains are easily performed laboratory tests when done by physicians trained in the technique; and

Whereas, a gram stain can give important preliminary clinical guidance to a physician choosing antibiotic therapy for a given patient; and

Whereas, cultures of various body fluids take a minimum of 48 hours to provide useful clinical data; and

Whereas, patients will be the sole entity harmed by the exclusion of gram stain from a physician armamentarium; and

Whereas, current CLIA regulations classify gram stains as a complex test, requiring an increased level of

lab proficiency with controls and purchased bacteria for the confirmation of the gram stain technique; therefore be it

RESOLVED, That the ISMA, through the AMA, petition the appropriate authorities to include gram stain performed by physicians as a physician-performed microscopy, much as urine microscopy, KOH prep and wet mounts; and be it further

RESOLVED, That this resolution be forwarded to the AMA I-94 meeting.

### **RESOLUTION 94-3      Tax-Exempt Hospitals Competing Against Tax-Paying Health Care Providers**

Introduced by: Vigo, Parke, Vermillion  
 County Medical Society  
 Referred to: Reference Committee 3  
 Action: Referred to Board of Trustees as amended

Whereas, tax-exempt hospitals throughout Indiana and the nation are competing against tax-paying health care providers in the delivery of outpatient health care services; and

Whereas, this is unfair competition with the tax-exempt hospital having a 40% to 50% tax advantage over the tax-paying provider; and

Whereas, it is also unfair to taxpayers and health care consumers since tax-exempt hospitals could better use these extra funds to reduce the cost of health care to the general public instead of using them to build unneeded health care facilities that compete directly against private practitioners and hospitals who do pay taxes; and

Whereas, the day is long gone when hospitals were charitable institutions as they originally were at their tax-free inception in the late 1800s and early 1900s when they did render charitable care, but now, with the inception of welfare and Medicaid, private insurance money and Medicare, they have as many or more financial resources as any health care provider and are no longer in need of their tax-exempt status; and

Whereas, they are abusing their tax-exempt status by using these county, state and federal moneys to build ever bigger and bigger institutions and to compete more and more with those who provide the tax money upon which they depend; therefore be it

RESOLVED, That the Vigo, Parke, Vermillion County Medical Society go on record stating that they



think every tax-exempt hospital in the state of Indiana should pay state income tax and county tax; and be it further

RESOLVED, That the House of Delegates understands that there are inequities in competition between tax-exempt and tax-paying providers; and be it further

RESOLVED, That the ISMA investigate methods for resolving the inequities in this type of unfair competition.

## **RESOLUTION 94-4      Prohibit Corporal Punishment in Indiana Schools**

Introduced by: John W. Luce, M.D., LaPorte County  
Referred to: Reference Committee 2  
Action: Adopted

RESOLVED, That current ISMA policy on corporal punishment be reaffirmed; and be it further

RESOLVED, That the ISMA encourage schools and licensed day care facilities to develop and implement effective, innovative, appropriate and positive behavioral management programs.

## **RESOLUTION 94-5      Financial Compensation to Primary Care Physicians Who Provide Training for Physicians in Training**

Introduced by: ISMA Subcommittee on Accreditation and Commission on Medical Education  
Referred to: Reference Committee 4  
Action: Adopted as amended

Whereas, there is a recognized need to encourage physicians in training to pursue careers in primary care; and

Whereas, there are many qualified primary care physicians who would be willing to take more time to provide a more meaningful exposure to primary care for physicians in training but who are currently not financially able to take this time, which is necessary to provide these physicians in training with this kind of exposure; and

Whereas, physicians in training can most likely be positively influenced by their exposure to preceptors/instructors who are themselves primary care physicians in active practice, and who are willing to take

adequate time to appropriately instruct and interact with these physicians in training; therefore be it

RESOLVED, That the ISMA continue to encourage funding to increase the number of primary care doctors by seeking legislative action and by communications with officials at the state or federal level.

## **RESOLUTION 94-6      Medical Licensing Board Registration Fees**

Introduced by: Executive Committee  
Referred to: Reference Committee 3  
Action: Adopted as amended

Whereas, only a portion of physician, medical licensure fees goes to support the Medical Licensing Board of Indiana and its investigative responsibilities; therefore be it

RESOLVED, That the Indiana State Medical Association review the work of the legislative committee studying professional licensing fees and consider whether or not legislative relief is appropriate when the legislative study is complete.

## **RESOLUTION 94-7      Indiana Medical Oncology Society**

Introduced by: Robert T. Woodburn, M.D., president, Indiana Medical Oncology Society  
Referred to: Reference Committee 1  
Action: Adopted

Whereas, the Indiana Medical Oncology Society meets on an annual basis in Indiana as the Indiana Medical Oncology Society; and

Whereas, the Indiana Medical Oncology Society records minutes of the annual meeting with duly elected officers; and

Whereas, oncology is a recognized medical specialty; and

Whereas, this resolution is signed by 19 practicing oncologists, which represents 34% of the membership as required by the ISMA Bylaws, Section 3.030104; therefore be it

RESOLVED, That the Indiana State Medical Association recognize the Indiana Medical Oncology Society as an official section as described in the ISMA Bylaws, Section 3.030103.

## ■ resolutions

### **RESOLUTION 94-8      Health Insurance for All ISMA Members**

Introduced by: Jasper-Newton County Medical Society  
 Referred to: Reference Committee 4  
 Action: Not adopted

Whereas, Indiana State Medical Association offers health insurance for its members; and

Whereas, that insurance is not available to all the members of the association, but only those who qualify and are physically able to qualify for this insurance; and

Whereas, some of our members have become uninsurable and have therefore ceased membership in our organization; therefore be it

RESOLVED, That health insurance be available to cover all the members of the Indiana State Medical Association, rather than just a few.

### **RESOLUTION 94-9A      Tougher Licensing Laws for Sale of Tobacco**

Introduced by: Third District Medical Society  
 Referred to: Reference Committee 3  
 Action: Adopted as Substitute Resolution for 94-9

Whereas, 23% of Indiana high school seniors smoke daily, compared with 18.5% nationally; and

Whereas, tougher licensing laws could make store owners more reluctant to sell to minors; therefore be it

RESOLVED, That the Indiana State Medical Association seek and support legislation that would:

- 1) Restrict the display of tobacco products in prominent places;
- 2) Prohibit cigarettes from being distributed in vending machines;
- 3) Toughen penalties for merchants selling tobacco products to minors; and
- 4) Institute retailers' cigarette licensure. And be it further

RESOLVED, That ISMA Resolution 94-9A be presented at the annual AMA meeting in 1995.

### **RESOLUTION 94-10      Scope of Practice for Advanced Nurses in Independent Practice**

Introduced by: Third District Medical Society  
 Referred to: Reference Committee 2  
 Action: Adopted amended Resolution 94-29 in lieu of 94-10

Whereas, the Indiana State Medical Association has long recognized the value of advanced practice nurses in extending health care services, particularly in underserved areas; and

Whereas, many ISMA members currently work with advanced practice nurses and appreciate the quality of their nursing skills as well as certain specialized skills that parallel those of physicians; and

Whereas, despite the present collegial relationship and similar vision for improved health care that these two professions share, many ISMA members are concerned that certain leaders in the nursing profession are promoting a very liberal interpretation of "collaboration" between physicians and nurses, and are in fact, outspoken in advocating the independent practice of medicine by advanced practice nurses; and

Whereas, the ISMA does not consider the education of advanced practice nurses to sufficiently qualify them to practice medicine independently; therefore be it

RESOLVED, That the ISMA support meaningful collaboration between physicians and advanced practice nurses in order to make health care more accessible to the citizens of Indiana; and be it further

RESOLVED, That collaboration be defined as a working arrangement between physicians and advanced practice nurses incorporating the following elements:

- a) A trained and licensed physician must play an integral part in directing the advanced practice nurse's efforts, and be responsible for the quality of care that is rendered;
- b) Advanced practice nurses must operate within the scope of their specialized education as well as within the scope of their collaborating physician;
- c) Collaboration must be frequent, periodic and contemporaneous with patient care; and
- d) Written protocols may facilitate the collaborative process, but they cannot stand as a substitute for it. And be it further

RESOLVED, That the Indiana State Medical



Association not support the independent practice of medicine by advanced practice nurses.

## **RESOLUTION 94-11 Dues-Delinquent Members**

Introduced by: ISMA Executive Committee  
Referred to: Reference Committee 1  
Action: Adopted

Whereas, Section 2.0101 of the ISMA Bylaws states in pertinent part,

"Dues are payable by Jan. 15 and become delinquent on that date. The Board of Trustees shall have the power to suspend any member who has not paid dues in full by April 30. The member shall sacrifice all rights and privileges of membership of this Association until said annual dues are received in full by the Indiana State Medical Association ..."; and

Whereas our Bylaws currently give the Board of Trustees the "power" but not the "mandate" to suspend a member who has not paid his dues in full by April 30; and

Whereas, currently under our Bylaws for the ISMA to formally drop a doctor from membership because of non-payment of dues by April 30, staff would first have to report to the Board of Trustees the doctors who are delinquent and request the Board for a specific directive on a physician by physician basis as to whether or not to drop the physician from membership; and

Whereas, this procedure is not practical for either the staff or the Board; and

Whereas, as a practical matter the county societies are in the best position to know which physicians should be dropped as members for non-payment of dues; therefore be it

RESOLVED, That the ISMA Bylaws dealing with non-payment of dues be modified to read as follows:

"Dues are payable by Jan. 15 and become delinquent on that date. The ISMA shall suspend any member who has not paid dues in full by April 30 when the county medical society notifies the ISMA in writing that the physician should be dropped from membership. The member shall sacrifice all rights and privileges of membership of this association until said annual dues are received in full..."

## **RESOLUTION 94-12 AMA Fiscal Note Accountability**

Introduced by: Barney R. Maynard, M.D.,  
District 1 trustee  
Referred to: Reference Committee 1  
Action: Adopted

Whereas, the AMA House of Delegates is charged with setting AMA policy and initiatives through the adoption of resolutions; and

Whereas, many of these resolutions and initiatives will have a significant impact on the financial status of the AMA as indicated in "fiscal notes" attached to resolutions and initiatives; and

Whereas, the total dollar figure listed as fiscal notes on resolutions submitted at the 1994 annual meeting of the AMA ranged from \$2,046,456 to \$3,611,456; and

Whereas, it is also the obligation of the House of Delegates of the AMA to be accountable for the fiscal stability of the AMA; and

Whereas, there currently is no method for the House of Delegates, the elected representatives of the membership, to track the actual expense of enacted resolutions and initiatives requiring funding; therefore be it

RESOLVED, That the ISMA submit a resolution to the AMA 1994 interim meeting of the House of Delegates that would direct the Board of Trustees and AMA staff to develop and present to the AMA House of Delegates at A-95 an understandable method of tracking the cost of enacted resolutions and initiatives; and be it further

RESOLVED, That there be at each AMA annual and interim meeting of the House of Delegates an update of the expenditures for each enacted resolution and initiative requiring funding for the life of each enactment.

## **RESOLUTION 94-13 Monitoring Insurance Company Payment Denials**

Introduced by: Tippecanoe County Medical Society  
Referred to: Reference Committee 1  
Action: Not adopted

Whereas, medical insurance companies often have capricious payment policies, designed more to prevent payment than to verify claims; therefore be it

RESOLVED, That the Indiana State Medical

## ■ resolutions

Association ask the American Medical Association to monitor payment denials and to seek criminal prosecution of insurance companies where a case of fraud and conspiracy to commit fraud is evident from these denial patterns.

### **RESOLUTION 94-14A Good Samaritan Statute**

Introduced by: ISMA Board of Trustees  
Referred to: Reference Committee 3  
Action: Adopted as amended as  
Substitute Resolution for 94-14

Whereas, the Indiana Appellate Court has narrowly construed Indiana's Good Samaritan Statute to apply only to accidents in the strictest sense of the term and not to all emergencies necessitating medical assistance; and

Whereas, if doctors in Indiana are to benefit from and truly be encouraged to render assistance in accident and emergency situations; therefore be it

RESOLVED, That the Indiana State Medical Association pursue legislative changes to the Good Samaritan Statute, which will clarify the intent of the Indiana legislature to apply the Good Samaritan Statute to not only accidents but also to emergency situations regardless of locality.

### **RESOLUTION 94-15A Protection of Patient Rights**

Introduced by: Vanderburgh County Medical Society  
Referred to: Reference Committee 3  
Action: Adopted as amended to include Resolution 94-24

Whereas, the AMA has introduced the Patient Protection Act on a federal level; and

Whereas, it is likely that health reform policy will ultimately be determined by states; and

Whereas, much of the reform debate will center on cost and access issues and may supersede the rights and choices of the patients; and

Whereas, many patients are and will continue to be insured under plans offered by their employer; and

Whereas, many of these plans restrict choice or do not pay for out of network physicians, thus creating an economic dis-incentive that effectively denies the patient their choice of physician; and

Whereas, many of these plans will tie a physician's

compensation to that physician's "efficient use of resources" as determined by the plan; and

Whereas, the rights of patients and the rights of physicians to appropriately treat patients without fear of retribution by the plan must be protected; therefore be it

RESOLVED, That the elements of the Patient Protection Act, as defined by the AMA, be a legislative initiative of the ISMA in the Indiana legislature to protect the rights and choices of Indiana patients and their physicians.

RESOLVED, That the ISMA draft and support legislation in the Indiana legislature requiring that any program arranging for, providing or financing medical care within the state of Indiana provide in each physician contract "due process" to any physician in determining, restricting, denying or expelling any such physician from participation in any such program.

### **RESOLUTION 94-16 Medical Relief Task Force**

Introduced by: Lawrence Bailey, M.D.,  
Dearborn/Ohio County  
Medical Society  
Referred to: Reference Committee 2  
Action: Referred to Board of Trustees

Whereas, a number of medical catastrophes are occurring throughout the world and others can be anticipated in the near future; and

Whereas, current medical relief agencies are, or are in danger of being overwhelmed; therefore be it

RESOLVED, That the ISMA assemble a Medical Relief Task Force composed of interested, dedicated and qualified physicians, nurses and others to aid in relief efforts.

### **RESOLUTION 94-17 Civil Immunity Law**

Introduced by: Fort Wayne Medical Society  
Referred to: Reference Committee 3  
Action: Adopted

Whereas, many Indiana medical doctors who have retired from practice or practice in settings where they no longer need, desire or, in some cases have, the financial ability to purchase medical malpractice insurance; and

Whereas, many of these physicians are willing to provide medical services without remuneration at



clinics for patients in underserved areas; and

Whereas, a need exists for these services and it is in the public interest that this care be delivered; and

Whereas, physicians feel legitimate victims of medical malpractice are entitled to relief; therefore be it

RESOLVED, That the ISMA support legislation that would permit physicians who volunteer their time in free clinics to be covered under the tort claims act.

## **RESOLUTION 94-18 Clinical Laboratory Accreditation Through COLA**

Introduced by: Indiana Society of Internal Medicine

Referred to: Robert Rudesill, M.D.

Action: Reference Committee 4  
Adopted

Whereas, the Commission on Office Laboratory Accreditation (COLA) is the only non-profit education and accreditation organization for the physician office laboratory established by the American Academy of Family Physicians, the American Medical Association, the American Society of Internal Medicine and the College of American Pathologists; and

Whereas, the federal CLIA '88 law gives physicians the right to seek accreditation by a private, non-profit accreditation program; and

Whereas, the Commission on Office Laboratory Accreditation is approved by the Health Care Financing Administration as an alternative to CLIA '88; therefore be it

RESOLVED, That the ISMA endorse the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation; and be it further

RESOLVED, That the ISMA publicize information about the Commission on Office Laboratory Accreditation through COLA in lieu of federal certification.

## **RESOLUTION 94-19 An American Concept for Responsible Health Care Funding**

Introduced by: Kenny E. Stall, M.D., Franklin

Referred to: Reference Committee 1

Action: Referred to Board of Trustees

Whereas, our national government and present administration is determined to pass current health care reform; and

Whereas, all predictions as to health care costs have consistently proven inaccurate; and

Whereas, adequate and proper funding of health care is essential to the ultimate delivery of care for every patient; and

Whereas, medicine has evolved to the point that it can accurately predict the behaviors and lifestyle activities, which ultimately are the origin for many of the illnesses, diseases and injuries that befall our citizens; and

Whereas, government reimbursement is already centered around only 490 DRGs, which establish a reimbursement rate for a specific illness, disease or injury; therefore be it

RESOLVED, That the ISMA ask the American Medical Association to support and encourage the formation of individual disease funds that will be used as reimbursement under any reform proposal, be it private pay, HMO, regional alliance or single-payer program, for those diseases, illnesses and injuries that are behavior-related; and be it further

RESOLVED, That the sources for those funds be gathered and advanced from the people who participate in or the industries that profit from or that glamorize those behaviors that ultimately lead to the illnesses, diseases and injuries that generate the cost of health care for those illnesses, diseases and injuries.

## **RESOLUTION 94-20 Health Insurance for All ISMA Members, Families & Employees**

Introduced by: Thomas H. Hollingsworth, M.D., Bloomington

Referred to: Reference Committee 4

Action: Not adopted

Whereas, as physicians we agree that all patients should have access to health insurance, and we often find that patients with pre-existing medical problems are denied insurance; and

Whereas, we desire our association's insurance program to be progressive and non-restrictive; therefore be it

RESOLVED, That the Indiana State Medical Association offer health insurance to its members, dependents and employees that does not exclude applicants on the basis of pre-existing disease.

## resolutions

### **RESOLUTION 94-21A Federal Tax Credit for Charity Care**

Introduced by: Gregg A. Dickerson, M.D.,  
Muncie  
Referred to: Reference Committee 1  
Action: Referred amended Substitute  
Resolution 94-21A to Board of  
Trustees

Whereas, there has been a significant decrease in physician professional reimbursement due to decreases in payment mandated by the federal Medicare program and the state Medicaid programs, and there have been significant increases in federal taxes, all of which affects the cost of operating a practice or delivering medical care and thereby causes the real income of physicians to decrease significantly; and

Whereas, reimbursement by the federal Medicare program and the state Medicaid program, in general, does not cover the expenses involved in delivering quality medical care to patients and necessitates cost shifting to maintain the quality of care delivered to beneficiaries; and

Whereas, physicians are ethically and morally bound to deliver medical care to patients regardless of their ability to pay, and can document the amount of charity care they deliver; therefore be it

RESOLVED, That the ISMA Board of Trustees commission a study on the impact of offering a tax credit to physicians for undercompensated Medicare and Medicaid services. The study should include the financial impact on physician income as well as loss of revenue to the government. The study should also include the impact on access to health care services to patients in these populations. And be it further

RESOLVED, That if the ISMA Board of Trustees finds this proposal to have merit, then it shall cause a resolution to be introduced to the AMA House of Delegates during the June 1995 meeting.

### **RESOLUTION 94-22 Third-Party Coverage for Mental Illness**

Introduced by: John J. Wernert III, M.D.,  
Indiana Psychiatric Society  
Referred to: Reference Committee 3  
Action: Adopted

Whereas, third-party payers have continued to discriminate against individuals with mental illness;

and

Whereas, 30 states currently require insurance companies to provide or offer minimum mental health benefits; and

Whereas, the development of new pharmaceutical agents and treatments have greatly increased the ability of physicians to treat individuals with biologically based mental illness (such as schizophrenia, delusional disorder, manic depressive disorder, panic disorder, obsessive compulsive disorder, attention deficit disorder and major depression); and

Whereas, numerous studies have shown the increased costs to society if these biological illnesses go untreated; therefore be it

RESOLVED, That the ISMA support legislation that requires third-party payers to treat biologically based mental illness in the same manner as other physical illnesses.

### **RESOLUTION 94-23 Medical Care Reimbursement by Medicare & Medicaid**

Introduced by: Lake County Medical Society  
Referred to: Reference Committee 4  
Action: Adopted as amended

Whereas, present Medicare and Medicaid reimbursements to patients or providers is below the generally accepted payment levels of the community; and

Whereas, excessively low payments lead to providers' inability to participate in such state and federal programs; and

Whereas, it is desirable to encourage participation in these federal and state programs; therefore be it

RESOLVED, That the ISMA continue to oppose the arbitrary and unfair levels of Medicare and Medicaid payment for medical care by presenting financial data to lawmakers and the executive branch.

### **RESOLUTION 94-24 Assurance of "Due Process" in Managed Care Contracts**

Introduced by: Lake County Medical Society  
Referred to: Reference Committee 3  
Action: Adopted Substitute Resolution  
94-15 to include 94-24

Whereas, managed care health care is growing in Indiana; and



Whereas, managed care affects or impacts medical practice through contractual agreements; and

Whereas, agreements may harm patient rights to care if physician access is unfairly restricted; and

Whereas, decency and fair play require some assurance of "due process"; therefore be it

RESOLVED, That the ISMA draft and support legislation in the Indiana legislature requiring that any program arranging for, providing or financing medical care within the state of Indiana provide in each physician contract "due process" to any physician in determining, restricting, denying or expelling any such physician from participation in any such program.

## **RESOLUTION 94-25    Changes in the Indiana Medical Licensing Board Emergency Procedures**

Introduced by: Lake County Medical Society  
Referred to: Reference Committee 3  
Action: Adopted as amended

Whereas, emergency procedures of the Indiana State Licensing Board are desirable to protect the health of the public; and

Whereas, such procedures, if hastily and erroneously used, can ruin the occupation and reputation of a provider; and

Whereas, the Indiana Attorney General's office is the office charged with recommending and pursuing license revocation (often in the absence of medical consultation); and

Whereas, fair play requires an opportunity for a provider to be heard before a precipitous license restriction; and

Whereas, provision of the right of a provider to be heard even in an emergency would neither slow the process nor threaten the public protection, and would prevent erroneous actions; therefore be it

RESOLVED, That the ISMA support changes to the state medical licensing board procedures that would require that in the case of an emergency suspension hearing, the physician would be notified, and allowed an opportunity to present a statement on his or her behalf during the emergency hearing even by phone if necessary; and be it further

RESOLVED, That the physician be permitted to show cause to hold off summary suspension; and be it further

RESOLVED, That prior to any hearing, greater

legal assistance be afforded to the licensing board and that greater medical consultation be afforded the Attorney General's office.

## **RESOLUTION 94-26    Elimination of Contingency Fees**

Introduced by: William Marcum, M.D., Perry County Medical Society  
Referred to: Reference Committee 1  
Action: Not adopted

Whereas, the cost of health care is a major concern to most Americans; and

Whereas, defensive medicine, in an effort to limit liability in malpractice actions, is a major contributing factor in the increasing cost of health care; and

Whereas, contingency fees on the part of trial lawyers have the effect of making malpractice actions more likely; therefore be it

RESOLVED, That the ISMA as well as the AMA seek provisions to any health care reform plan that would eliminate contingency fees and set limits on total damages not to exceed \$750,000.

## **RESOLUTION 94-27    ISMA Membership for Physicians Practicing in Veteran Administration Hospitals**

Introduced by: Fort Wayne Medical Society  
Referred to: Reference Committee 4  
Action: Not adopted

Whereas, physicians who practice at the VA Hospital in Fort Wayne have indicated an interest in membership in the Fort Wayne Medical Society; and

Whereas, similar VA hospitals in other areas of Indiana may also have physicians who wish to join local medical societies; and

Whereas, VA physicians, because of their status as federal employees, do not believe that ISMA membership can assist them at the same level as independent or group practitioners; and

Whereas, the ISMA Bylaws and local medical societies require a dual membership in both organizations; therefore be it

RESOLVED, That the ISMA establish a class of membership for VA physicians with a reduced dues structure, perhaps with some limitations on ISMA

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benefits, and permit local medical societies to also establish a separate membership class for this group of physicians, if they so desire.

**RESOLUTION 94-28     Equitable Reimbursement**  
Introduced by:     Indiana Academy of Family Physicians  
Referred to:     Reference Committee 1  
Action:     Adopted in lieu of Resolution 94-36

Whereas, the Indiana State Medical Association is dedicated to the proposition that all citizens of Indiana should have reasonable access to primary medical care; and

Whereas, the rural areas are the most medically underserved areas; and

Whereas, the current method of calculating RBRVS Medicare reimbursement is unfairly lower for rural localities; and

Whereas, recruiting to rural areas is adversely affected by this lower Medicare reimbursement; and

Whereas, HCFA has recently commented in the *Federal Register* that they would rather have one set of locality factors for an entire state, but they need physicians' input to justify the change; and

Whereas, most major insurance carriers will likely adopt RBRVS in the near future, furthering the inequitable reimbursement for rural physicians; therefore be it

RESOLVED, That the ISMA pursue with HCFA a single, statewide locality designation for the purpose of RBRVS reimbursement and that the ISMA gather the data and information needed to justify the change.

**RESOLUTION 94-29     Advanced Practice Nurses**  
Introduced by:     Indiana Academy of Family Physicians  
Referred to:     Reference Committee 2  
Action:     Adopted as amended in lieu of Resolution 94-10

Whereas, the Indiana State Medical Association has long recognized the value of advanced practice nurses in extending health care services, particularly in underserved areas; and

Whereas, many ISMA members currently work with advanced practice nurses and appreciate the

quality of their nursing skills as well as certain specialized skills that parallel those of physicians; and

Whereas, despite the present collegial relationship and similar vision for improved health care that these two professions share, many ISMA members are concerned that certain leaders in the nursing profession are promoting a very liberal interpretation of "collaboration" between physicians and nurses and are, in fact, outspoken in advocating the independent practice of medicine by advanced practice nurses; and

Whereas, the Nursing Scope of Practice Act of 1993 allows advanced practice nurses to practice medicine independently without significant physician collaboration; and

Whereas, the ISMA does not consider the education of advanced practice nurses to sufficiently qualify them to practice medicine independently; therefore be it

RESOLVED, That the ISMA support meaningful collaboration between physicians and advanced practice nurses in order to make health care more accessible to the citizens of Indiana; and be it further

RESOLVED, That collaboration be defined as a working arrangement between physicians and advanced practice nurses incorporating the following elements:

- a) A trained and licensed physician must play an integral part in directing the advanced practice nurse's efforts, and be responsible for the quality of care that is rendered.
- b) Advanced practice nurses must operate within the scope of their specialized education as well as within the scope of their collaborating physician.
- c) Collaboration must be frequent, periodic and contemporaneous with patient care, as well as continuous when indicated by acuity of care being delivered.
- d) Written protocols cannot stand as a substitute for the collaborative process. And be it further

RESOLVED, That the ISMA not support the independent practice of medicine by advanced practice nurses; and be it further

RESOLVED, That the ISMA continue to educate the public and state legislators on this issue.



**RESOLUTION 94-30A Injection of Medicine by Syringe/Needle by Paramedical Personnel**

Introduced by: William R. Vaughn, M.D., Vincennes  
 Referred to: Reference Committee 3  
 Action: Adopted as Substitute Resolution for 94-30

Whereas, the Indiana Medical Practice Act, Section 2, I.C. 25-22.5-1-1.1 defines the practice of medicine or osteopathic medicine as the performing of any kind of surgical operation upon a human being including tattooing, in which human tissue is cut, burned or vaporized by the use of any mechanical means, laser or ionizing radiation or the penetration of the skin or body orifice by any means, for the intended palliation, relief or cure; and

Whereas, many paramedical provider groups are attempting to broaden their scope of practice by administering medications to humans by injection; and

Whereas, these groups are not adequately trained in many aspects of medical care; and

Whereas, the quality of care Indiana patients are receiving may be compromised; therefore be it

RESOLVED, That the ISMA seek to clarify regulations concerning individuals administering injections to humans in order to reaffirm the understanding that this should only be under the direction of physicians, podiatrists and dentists and with adequate supervision to ensure patient safety.

**RESOLUTION 94-31 The Physicians' Response to Family Violence**

Introduced by: ISMA/ISMA Alliance Family Violence Task Force  
 William Cooper, M.D., chairman  
 Referred to: Reference Committee 2  
 Action: Adopted as amended

Whereas, violence among family members has reached staggering proportions; and

Whereas, every year between 2 million and 4 million women are battered by their spouse, and more than 2 million cases of child abuse and neglect are reported, and approximately 1.1 million of the dependent elderly population are abused; and

Whereas, 75% of battered women first identified in

a medical setting will go on to suffer repeated abuse, and domestic violence kills nearly as many women each decade as the number of Americans who lost their lives in the Vietnam War; and

Whereas, physicians may be the first non-family member to whom an abused patient turns for help; and

Whereas, family violence and its medical and psychiatric consequences are sufficiently prevalent to justify routine screening of all patients, in emergency, surgical, primary care, pediatric, prenatal, geriatric and mental health settings; therefore be it

RESOLVED, That the ISMA recommend the following steps in recognizing and treating victims of family violence:

- 1) Routinely ask specific questions about abuse during the patient's social history, past medical history or history of present illness;
- 2) Ask directly about violence with such questions as "At any time has a partner hit, kicked or otherwise hurt or frightened you?";
- 3) Interview your patient about these questions in private at all times;
- 4) Document your findings. Information about suspected family violence in the patient's chart can serve a valuable function in court should the patient decide to seek legal redress. A physician's documentation could validate the patient's position;
- 5) Assess your patient's safety before they leave the medical setting; and
- 6) Review options with your patient. Know the referral organizations available to patients in your area such as shelters, legal advocacy, counseling and support groups. Provide the patient with local and/or state hotline numbers. And be it further

RESOLVED, That the ISMA continue to take all reasonable steps to disseminate family violence information to all practicing physicians.

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**RESOLUTION 94-32    Family Violence – Medical School Training**  
Introduced by: ISMA/ISMA Alliance Family Violence Task Force  
William Cooper, M.D., chairman  
Referred to: Reference Committee 2  
Action: Adopted as amended

Whereas, estimates from the National Crime Survey put the annual medical cost of domestic violence at almost 100,000 days of hospitalization, almost 30,000 emergency room visits and almost 40,000 visits to a physician each year; and

Whereas, a study conducted at Rush Medical Center in Chicago found that the average charge for medical services provided to abused women, children and older people was \$1,633 per person per year, amounting to a national annual cost of \$857.3 million; and

Whereas, as many as 35% of women who visit hospital emergency rooms are there for symptoms related to on-going abuse and only a small percentage (1 in 25) are recognized as battered women by their physician; and

Whereas, AMA research shows that 80% of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence; and

Whereas, a medical encounter may provide the only opportunity to break the cycle of abuse in family violence before repeated injuries can occur; therefore be it

RESOLVED, That the Indiana State Medical Association encourage the Curriculum Committee of the Indiana University School of Medicine to expand its present training on family violence. And be it further

RESOLVED, That the ISMA also encourage ongoing education on family violence of physicians in training, physicians in practice and the general public.

**RESOLUTION 94-33A    Negotiating Health Care Levels & Fees Under Managed Care Programs**  
Introduced by: Lake County Medical Society  
Referred to: Reference Committee 3  
Action: Adopted as Substitute Resolution for 94-33

Whereas, managed care is becoming dominant in health care; and

Whereas, managed care typically involves contracts between providers and insurers; and

Whereas, the ability to negotiate on behalf of providers to assure quality patient care and fair treatment is presently proscribed by federal laws unless under state action; and

Whereas, it is in the interest of all to allow equitable status at a negotiating table between payers and providers; therefore be it

RESOLVED, That the ISMA Board of Trustees consider the development of legislation along the lines of the AMA model bill titled "Health Care Provider Network Negotiations Act" for introduction in the Indiana General Assembly as deemed appropriate.

**RESOLUTION 94-34    Reporting Mechanism for Children Screened for Anemia & Lead**  
Introduced by: Betty J. Campbell, M.D., Terre Haute  
Referred to: Reference Committee 2  
Action: Referred to the Board of Trustees for implementation

Whereas, an increasing large percentage of Indiana infants and children are covered by services for Women, Infants and Children (WIC); and

Whereas, many of these infants and children also receive services from the well child clinics; and

Whereas, one of the mandates of the Medicaid program and several other insurance carriers have guidelines that require periodic screening for anemia and lead; and

Whereas, these are screenings that are performed on a routine basis by WIC and by the well-child clinics; therefore be it

RESOLVED, That the ISMA seek a reporting mechanism to physicians when these screens have been performed, which would result in eliminating the



duplication of services and increase coordination of patient care.

**RESOLUTION 94-35    Reporting Mechanisms for Childhood Immunizations**

Introduced by: Betty J. Campbell, M.D., Terre Haute  
 Referred to: Reference Committee 2  
 Action: Referred to Board of Trustees

Whereas, many infants and children receiving services through Women, Infants and Children, (WIC) and child clinic facilities also receive part or all of their immunizations at such clinics; therefore be it

RESOLVED, That the ISMA encourage, for the purposes of documentation of immunizations and continuity of care, that whenever a primary physician is designated, a report of such immunizations be made to that physician.

**RESOLUTION 94-36    Statewide Single Medicare Reimbursement Region**

Introduced by: James A. Fountain, M.D., Indianapolis  
 Referred to: Reference Committee 1  
 Action: Adopted Resolution 94-28 in lieu of 94-36

Whereas, the current system of calculating RBRVS Medicare reimbursement divides the state of Indiana into three regions, labeled I, II and III and correlating supposedly with "urban," "suburban" and "rural"; and

Whereas, reimbursement is lower for "suburban" than for "urban" and lower for "rural" than for "suburban"; and

Whereas, this reimbursement system is capricious, irrational and outmoded, in that in the 30 years since this system was adopted, rural areas have become urban and suburban, and the process continues with no method for revising region boundaries; and

Whereas, the supposition that practice costs are less in rural areas justifies decreased reimbursement, can be challenged since lower costs of rent and salaries are offset by higher costs of equipment supply, maintenance and professional and technical support; and

Whereas, the current system of lower reimbursement in rural areas also provides a disincentive for physicians to practice in rural areas and this disincentive

contributes to a widely recognized imbalance in the physician/patient ratio between urban and non-urban areas, and this imbalance creates the potential for decreased access to care by citizens in rural areas; therefore be it

RESOLVED, That the ISMA investigate the procedures used by Ohio and Iowa to present the case to HCFA for a statewide area; and be it further

RESOLVED, That the ISMA support the adoption of a statewide single Medicare reimbursement region for calculations of RBRVS Medicare reimbursement.

**RESOLUTION 94-37    Quality Assurance Program**

Introduced by: Lee Smith Jr., M.D., Mishawaka  
 Referred to: Reference Committee 4  
 Action: Not adopted

Whereas, a mechanism exists to assure quality in the medical practice of hospital staffs; and

Whereas, cost containment has become a critical issue in developing new health care systems; and

Whereas, a more revealing picture of the advances in medicine and the practicalities related to those advances might lead to a more economical and rapid diagnostic treatment window for suffering patients; therefore be it

RESOLVED, That the ISMA,

- a) Through the quality assurance programs, do a study of the practice management patterns of physicians done with the aid of computer collection of data to discover the patterns of practice in areas of infectious disease, physical trauma, autoimmune disease, genetics, teratology, parasitic disease and functional or conditioned dysfunctional problems. These may be studied one at a time to gain experience for moving into the other areas and to study the overlapping areas, and new areas may be added; and
- b) That this resolution be sent to each county medical society and hospital for dissemination, or any other entity that might be enhanced by so doing; and
- c) That a report be sent by any entity now practicing anything like this to the ISMA Board of Trustees for compilation and experience sharing for any appointed committee or ad hoc group the Board of Trustees would feel legitimate

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mate; and

- d) That a summary of such activity be published annually in *INDIANA MEDICINE*.

### **RESOLUTION 94-38 Physician Provider & Insurance Payer Communication**

Introduced by: Herbert Trier, M.D., Fort Wayne  
 Referred to: Reference Committee 4  
 Action: Referred to Board of Trustees as amended

Whereas, there is considerable difficulty in transferring information between provider and reviewers for the purpose of authorizing review and certification and we have attempted to solve this problem by use of fax technology but in the past an attempt to use this method has met with rejection by insurance payers; and

Whereas, we feel that being allowed to fax information as an attempt to communicate with insurance payers will increase efficiency and accuracy; and

Whereas, such a method would avoid repeated attempts for one party to contact the other; and

Whereas, this method would also prevent misquoting the accuracy as to what was said; therefore be it

RESOLVED, That the ISMA support legislation that would make fax communication with regard to insurance claim information as acceptable as verbal telephone communication and encourage insurance companies to fax questions that need to be answered for review and certification, and that the provider be allowed to fax answers.

### **RESOLUTION 94-39 AMA Position on Gun Control**

Introduced by: Rick Robertson, M.D., Indianapolis  
 Referred to: Reference Committee 1  
 Action: Adopted

Whereas, crime and violence are universally recognized as serious problems in our society; and

Whereas, lawmakers have proposed several gun control provisions as a solution to the problem; and

Whereas, the problem of gun-related violence has traditionally been studied by sociologists and criminologists with only recent efforts by public health

professionals; and

Whereas, medical studies on firearms and violence have been hampered by a lack of available data to allow sound epidemiological studies on the morbidity and mortality associated with firearms, much less to allow evaluation of the impact of such legislation; and

Whereas, most of the information used to rationalize such legislation is presented by the mass media in a one-sided manner; and

Whereas, members of the AMA need to be unified to protect the greatest health care system in the world and taking unwarranted positions on such controversial issues can only divide and weaken our efforts; therefore be it

RESOLVED, That the ISMA delegation to the AMA House of Delegates cause a resolution to be introduced at the next meeting of the AMA House of Delegates that the AMA not support any legislation that would affect the access to and use of firearms by law abiding citizens; and be it further

RESOLVED, That the delegation request that instead the AMA support scientific research and cause objective discussion aimed at identifying causes of and solutions to the crime and violence problem that do not erode the fundamental liberties that are essential to the long-term survival of our republic.

### **RESOLUTION 94-40 Medicaid Reform**

Introduced by: Indiana Chapter, American College of Emergency Physicians  
 John McGoff, M.D.  
 Referred to: Reference Committee 4  
 Action: Referred to the Board of Trustees

Whereas, 42 U.S.C. 1935dd mandates a medical screening exam for all patients presenting to an emergency department requesting care; and

Whereas, the screening exam must also avail itself to all hospital ancillary services including lab and x-ray; and

Whereas, Indiana's Office of Medicaid Policy and Planning has established a new Primary Care Case Management program, which refuses payment for emergency physicians or hospitals when the visit is deemed "routine"; and

Whereas, these policies will result in decreased access to emergency departments for Medicaid patients



and offer no reimbursement mechanism for emergency physicians; therefore be it

RESOLVED, That the ISMA work with the governor's office and the Indiana General Assembly to ensure access to the emergency department for all Medicaid patients and ensure a mechanism of reimbursement for emergency physicians for all patients evaluated in the emergency department.

**RESOLUTION 94-41 All-Rider Helmet Use Mandate**

Introduced by: Indiana Chapter, American College of Emergency Physicians  
John McGoff, M.D.  
Referred to: Reference Committee 2  
Action: Adopted

Whereas, Section 153 of the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA), a program created several years ago to encourage states to enact safety belt and all-rider motorcycle helmet use laws, and a law that is unique in that it does not sanction states, and our state will therefore not lose a penny of federal funds; and

Whereas, Section 153 is a priority of the health, safety and business communities, and hundreds of groups that represent hundreds of thousands of Americans support this program and have worked for its implementation; and

Whereas, it is our opinion that our state's resources would be better spent helping our own state comply with Section 153 rather than attempting to undermine this program; and

Whereas, in a poll conducted by *The Indianapolis Star*, more than 70% of Hoosiers support a mandatory helmet law; and

Whereas, at a time when everyone is concerned with rising health care costs, a basic injury prevention program that will help lessen the burdens of our emergency departments, hospitals, rehabilitation centers and welfare programs should be a priority; and

Whereas, when people are injured in motor vehicle crashes, taxpayers pick up much of the bill and pay up to 80% of the cost of injured motorcyclists; and

Whereas, mandatory safety belt and helmet use is proven to prevent injuries and deaths. According to NHTSA, with 100% motorcycle helmet use, our state would have saved 18 lives and \$17.9 million in 1992

alone, and 210 lives and \$228.1 million would have been saved from 1984 to 1994; therefore be it

RESOLVED, That the state of Indiana needs both a safety belt law and an all-rider motorcycle helmet use law, and that the ISMA support Section 153 and seek enactment of a new state all-rider motorcycle helmet law.

**RESOLUTION 94-42 Domestic Violence**

Introduced by: Indiana Chapter, American College of Emergency Physicians  
John McGoff, M.D.  
Referred to: Reference Committee 2  
Action: Adopted as amended

Whereas, domestic violence is the single most common cause of injury to women; and

Whereas, the lack of appropriate resources results in inadequate medical, social and legal services for victims of domestic violence; and

Whereas, the American Medical Association has developed domestic violence protocols; and

Whereas, health codes in some states require emergency services to develop policies and procedures in all cases of suspected or confirmed domestic violence; therefore be it

RESOLVED, That it is the policy of the Indiana State Medical Association to work with the Indiana General Assembly in passing meaningful domestic violence legislation.

**RESOLUTION 94-43 Poison Control Centers**

Introduced by: Indiana Chapter, American College of Emergency Physicians  
John McGoff, M.D.  
Referred to: Reference Committee 2  
Action: Adopted

Whereas, there were over 1.5 million calls to Poison Control Centers in 1989 and estimates of actual poisonings were over twice that amount; and

Whereas, a majority of the poisonings reported were in children under the age of five, and 80-90% of hospital admissions due to poisoning are the result of adult poisoning; and

Whereas, Methodist Hospital in Indianapolis is

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currently the only Poison Control Center operating in Indiana and is severely financially strained; therefore be it

RESOLVED, That the ISMA support the concept of a statewide poison control system; and be it further

RESOLVED, That the ISMA strongly advocate adequate state funding for the Poison Control Center.

### **RESOLUTION 94-44 Including of "Any Willing Provider" & "Freedom of Choice" in Any Health Care Reform Legislation**

Introduced by: Indiana Society of Internal Medicine

Referred to: Reference Committee 1

Action: Adopted as amended

Whereas, the medical profession is likely to be induced to adapt to a new and different economic system of practice by current laws being promulgated by the Congress of the United States of America; and

Whereas, alliances and sponsored managed care plans including PPOs and HMOs will be anticipated to present a monopoly involving well over half of the population and controlling many potential patients away from independent fee-for-service private practice physicians; and

Whereas, the managed care entities including PPOs and HMOs are permitted in the pending legislation to discriminate among qualified and legally licensed providers (physicians) in the selection of their members; and

Whereas, this condition is contrary to every physician's economic freedom and creates a situation where the participating physician may be coerced regarding medical judgments and working conditions; therefore be it

RESOLVED, That the ISMA work to petition and otherwise influence our legislators to include firm stipulations of "any willing physician provider" and "freedom of choice" in any law establishing medical care schemes in the United States of America; and be it further

RESOLVED, That any physicians otherwise qualified be accepted to participate in any government-sponsored managed care plans irrespective of race, sex, age or religion.

### **RESOLUTION 94-45 Radiation Oncology Section**

Introduced by: Madison County Medical Society

Referred to: Reference Committee 1

Action: Adopted

Whereas, radiation oncologists meet annually in the state of Indiana as the Indiana Society of Radiation Oncology; and

Whereas, the Indiana Society of Radiation Oncology records minutes of the annual meeting with duly elected officers; and

Whereas, radiation oncology is a recognized medical specialty; and

Whereas, this resolution is signed by 20 practicing radiation oncologists, which represents 25% of the members, as required by ISMA Bylaws, Section 3.030104; therefore be it

RESOLVED, That the Indiana State Medical Association recognize radiation oncology as an official section as described in the ISMA Bylaws, Section 3.030103.

### **RESOLUTION 94-46 Ad Hoc Task Force on Managed Care**

Introduced by: Floyd County Medical Society  
C.M. Hocker Jr., M.D.,  
secretary

Referred to: Reference Committee 3

Action: Adopted as amended

Whereas, health care reform has and does create many models and forms of health care; and

Whereas, many of the managed care models are new, evolving and have characteristics and components that are difficult to understand; and

Whereas, some plans have reimbursement schedules that are confusing, fluctuating and not always consistent; and

Whereas, participation in these managed care plans by physician providers should be determined after careful study of timely and accurate information; and

Whereas, those data are often difficult to acquire, leading to decisions regarding participation that are made without true informed understanding, which may cause confusion and potential harm to patients; therefore be it

RESOLVED, That the Indiana State Medical Association consider the appointment of an Ad Hoc



Task Force on Managed Care whose mission would be to:

- 1) Gather timely and useful information on the most frequently utilized plans in Indiana, and
- 2) Make this information available to ISMA members on a regular basis.
- 3) Develop guidelines for review of managed care contracts.

**RESOLUTION 94-47 HHS, HCFA, Medicaid, PRO, Indiana State Department of Health & JCAHO Regulation**

Introduced by: Robert J. Steele, M.D., Kokomo  
 Referred to: Reference Committee 3  
 Action: Adopted

Whereas, the greatest problem facing medicine today is rising costs; and

Whereas, as much as one-third of total health expenditures are now being consumed by administrative costs and the cost of regulatory compliance; and

Whereas, the regulatory agencies, both governmental and private, are forced to endlessly promulgate new regulations to justify their on-going existence; and

Whereas, it is becoming increasingly more costly to comply with these new regulations and their benefit to patients is becoming even smaller; and

Whereas, hospitals are being forced to lay off nurses and other patient care employees while at the same time increasing employment of non-patient care areas in order to comply with ever more complex regulations; and

Whereas, every minute spent by physicians and other caregivers complying with regulatory and bureaucratic demands is a minute taken away from patient care; therefore be it

RESOLVED, That the ISMA House of Delegates instruct the Committee on Medicare Relations, other relevant committees and the administrative staff to

vigorously challenge the current patterns of harassment, micro-management and counterproductive regulations imposed on physicians and hospitals by HHS, HCFA, Medicaid, PROs, the Indiana State Department of Health and JCAHO. And be it further

RESOLVED, That the relevant committees and staff are strongly urged, where necessary, to inform our elected representatives, both state and federal, of the pernicious and counterproductive regulatory climate in which we are forced to practice medicine, and to seek their active intervention to effect changes in all regulatory bodies that will lead to more cost-effective and higher quality health care for our patients.

**RESOLUTION 94-48 To Honor George T. Lukemeyer, M.D.**

Introduced by: Indianapolis Medical Society

Whereas, George T. Lukemeyer, M.D., is ending a long career of distinguished service to the Indianapolis Medical Society, the Seventh District delegation, the Indiana State Medical Association and the American Medical Association; and

Whereas, Dr. Lukemeyer has made exceptional contributions in the fields of medical education, organized medicine and dedication to the IU School of Medicine's Admissions Committee; and

Whereas, medical education at the local, state and national levels has been strengthened by his efforts; and

Whereas, his political erudition and expertise at the city, state and national levels will be sorely missed; therefore be it

RESOLVED, That this 1994 ISMA House of Delegates publicly acknowledge their appreciation for the extensive contributions of George T. Lukemeyer, M.D., to medical education and his exemplary, sustained commitment to organized medicine. ■

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## Reference Committee members

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### Reference Committee 1

#### Annual reports, ISMA/AMA matters, Constitution and Bylaws

Rex Ragsdale, M.D., chairman, Evansville  
William Mohr, M.D., Kokomo  
Frank Frable, M.D., Aurora  
James McCallum, M.D., Indianapolis  
Kathleen Galbraith, M.D., Portland

### Reference Committee 2

#### Community health issues

Lana Patch, M.D., chairman, Huntington  
John Slack, M.D., Indianapolis  
Charles Dinwiddie, M.D., Muncie  
Barbara Bourland, M.D., Lafayette  
James Reidy, M.D., Mishawaka

### Reference Committee 3

#### Legislative issues

Gerald Walthall, M.D., chairman, Indianapolis  
Steve Tharp, M.D., Frankfort  
Girdhar Ahuja, M.D., Indianapolis  
Syed Ali, M.D., Boonville  
Jac Cooper, M.D., Valparaiso

### Reference Committee 4

#### Annual reports, member services and insurance-related issues

Larry Bailey Jr., M.D., chairman, Aurora  
Mohan Rao, M.D., Fort Wayne  
Sandra Gadson, M.D., Gary  
John Schneider, M.D., Indianapolis  
William Vaughn, M.D., Vincennes □

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# ISMA Fifty Year Club



The Indiana State Medical Association honors 62 physicians this year in recognition of their 50 years of service as loyal and devoted practitioners of medicine. These new members of the Fifty Year Club will join the roster of other distinguished Hoosier physicians inducted into the Fifty Year Club since its inception in 1948.

The ISMA wishes to formally acknowledge the following physicians for their unselfish service to their patients and profession:

Roy J. Ault, M.D., Terre Haute  
 Joseph A. Bergan, M.D., Lake Dallas,  
 Texas  
 Henry W. Bopp, M.D., Terre Haute  
 Ralph O. Bosch, M.D., Seymour  
 Ira K. Brandt, M.D., Santa Paula, Calif.  
 John Brincko, M.D., Portage  
 Thomas C. Brown Jr., M.D., Vincennes  
 Ralph F. Carlson, M.D., Evansville  
 Paul V. Chivington Jr., M.D., Carmel  
 Floyd B. Coleman, M.D., Waterloo  
 William W. Dalton, M.D., Indianapolis  
 W.M. Dickerson, M.D., Monticello  
 Tom H. Ebbinghouse, M.D., Richmond  
 John Ellett, M.D., Coatesville  
 George M. Ellis, M.D., Connersville  
 Thomas J. Fountaine, M.D., Bedford  
 Harley H. Frey, M.D., Lafayette  
 James L. Garrison, M.D., Indianapolis  
 William H. Getty, M.D., Evansville  
 Charles O. Hamilton, M.D., Lakeville  
 Robert W. Harger, M.D., Indianapolis  
 Verne K. Harvey Jr., M.D.,  
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# Acquired respiratory failure in critically ill patients

Rahman Pourmand, M.D.  
Indianapolis

With the recent advancement of medical technologies and significant progress in medicine, the frequency of admission to the intensive care unit (ICU) is increasing. Severely ill patients, suffering from a trauma or medical illness, can now be kept alive longer and have a better chance of functional recovery. Some patients who require a prolonged stay in the ICU may develop neurological complications that are often due to sepsis and subsequent multiple organ failure (MOF).

Such complications have gained attention only in recent years. The purpose of this review is to alert practitioners of such complications, which particularly affect the respiratory system and cause delay of ventilator weaning.

## Critical illness

Previously the term critically ill patient referred to the individual who was at imminent risk for death. In recent years, critically ill patients have had a better chance of survival from the acute phase of injury or illness. However, due to multiple therapeutic interventions and invasive procedures such as intubation, mechanical ventilation and/or placement of central access for parenteral nutrition and hemodynamic monitoring, patients in the ICU may become septic and develop organ failure.

Critical illness (CI) is now considered to be the combination of sepsis and MOF.<sup>1-6</sup>

Sepsis is a systemic response to an infectious process with or without positive blood cultures of invading or dividing organisms.<sup>7</sup> Thus, sepsis is not directly due to the presence of organisms but is the response of the body to their metabolic byproducts.

MOF is defined as a significant dysfunction of at least two major organ systems, commonly the lungs and the brain, followed by other organs.<sup>5,6</sup>

CI is estimated to occur in about 5% of patients admitted to the ICU in hospitals with ICU admission rates greater than 1,000 patients per year but probably higher in some hospitals.<sup>1</sup> Patients most susceptible to the development of this syndrome are elderly people with multiple medical problems and lower resistance to an infection who often stay longer in the ICU.<sup>8</sup> Mortality among CI patients is approximately 60%.<sup>8,9</sup> Among the survivors, 70% will develop neurological complications.<sup>1,2</sup> These complications have a rather specific pattern of presentation. They commonly begin with an encephalopathy (septic) with variable degrees of severity, followed by neuromuscular symptomatology (peripheral nerve and muscle).

## Neuromuscular complications

These complications recently have gained attention in the medical

and neurological literature. This delay of recognition is related to two factors: the difficulty of performing an adequate neuromuscular examination in the ICU patient and the concern of the primary physician, who is focusing primarily on the management of these patients.

The effect of CI on the peripheral nervous system is predominantly on the peripheral nerves, causing a polyneuropathy followed by a myopathy. Anterior horn cell, nerve root, plexus and neuromuscular junction are generally spared.

The primary clinical clue to the presence of these complications is difficulty in weaning the patient from the ventilator. This often prompts neurological consultation.<sup>3,10,11</sup>

## Critical illness polyneuropathy

Critical illness polyneuropathy (CIP) recently has been recognized as a cause of an acquired polyneuropathy in the ICU.<sup>12-14</sup> Approximately 50% to 70% of patients with CI who require a stay longer than two weeks in the ICU may develop this form of polyneuropathy.<sup>1,5,6</sup> This incidence is based upon a prospective study using clinical and electromyographic (EMG) features of such patients.<sup>1</sup> Clinical features usually depend on the severity of the neuropathy, duration of CI and duration of stay in the ICU. In its mild form, in addition to ventilatory failure, patients may show

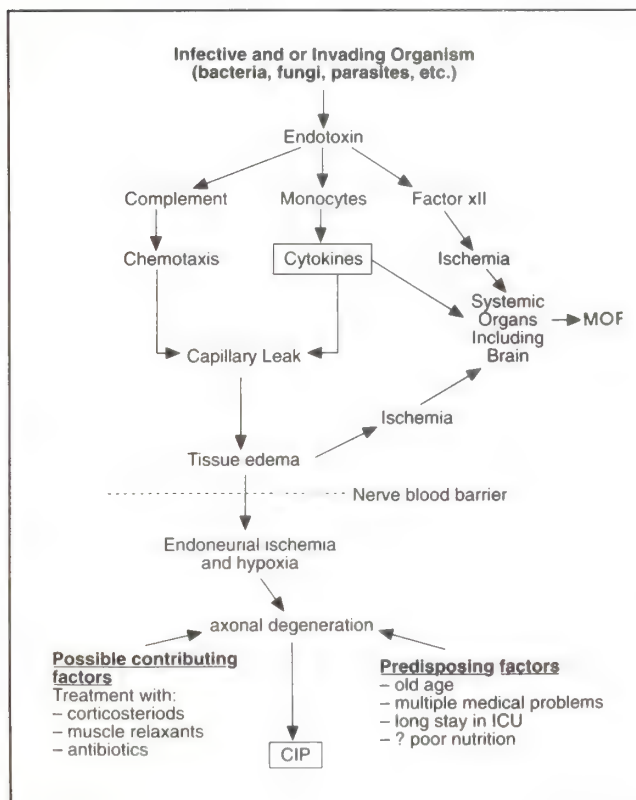


weakness of limbs and diminished or absent reflexes. In this stage, the condition may be overlooked on routine examination. In severe cases CIP is clinically evident. The patients are quadriparetic or quadriplegic and, as well, are areflexic. Cranial nerve function is generally preserved. Muscle atrophy, particularly intrinsic hand muscles, is commonly seen.<sup>15</sup> Hand muscle atrophy, however, also may be seen in CI patients without a polyneuropathy.<sup>16,17</sup>

An EMG study will aid significantly in establishing the diagnosis.<sup>18,19</sup> It will demonstrate evidence of an axonal type of polyneuropathy, in which the amplitude of motor and sensory nerve action potentials is decreased, conduction velocities and distal latencies are relatively normal, and needle examination of the muscles shows acute or chronic denervation potentials. EMG is also used to differentiate other neuromuscular diseases such as Guillain-Barre syndrome (GBS), in which the EMG findings are consistent with demyelinating neuropathy.<sup>20</sup> Serum creatine kinase and cerebrospinal fluid examination are commonly normal. Nerve and/or muscle biopsy may be considered for atypical cases.

### Myopathy

Although many forms of myopathic conditions such as septic myopathy, fascicular muscle necrosis and disuse myopathy have been reported with CI, none of these myopathies have been conclusively demonstrated or have been adequately studied.<sup>2,4</sup> Recently, a reversible acute or subacute myopathy has occurred in patients receiving high doses of corticosteroids with neuromuscular blocking agents, such as



**Proposed mechanism of sepsis causing polyneuropathy:**  
CIP = critical illness polyneuropathy;  
MOF = multiple organ failure.

vecuronium or pancuronium, the medications commonly used in the ICU.<sup>22,23</sup> These patients presented with generalized and respiratory muscle weakness. Electron microscopy of the muscle fibers shows loss of myosin filaments.

### Neuromuscular transmission

Neuromuscular transmission function has been normal in most CI patients.<sup>19,20</sup> Severe axonal neuropathy, however, may show a defect in neuromuscular transmission demonstrated by electrophysiological studies.<sup>22</sup> Non-depolarizing agents may block the neuromuscular junction which, at times, could cause persistent weakness.<sup>25,26</sup>

### Pathogenesis

The proposed mechanism of nerve

and muscle complications of sepsis is shown in the *Figure*. Although treatment modalities may certainly play a role in pathogenesis, in most large series the cause is likely related to the systemic effects of the sepsis itself. The critical insult is hypoperfusion and ischemia with a mild degree of edema of the nerve and muscle, causing axonal degeneration and muscle necrosis.<sup>1,2,4,15,27</sup>

### Diagnosis

In CI patients, particularly the elderly, primary lung disease such as pneumonia, chronic obstructive pulmonary disease and V/Q mismatch, either acute or chronic, are invariably present. However, if these conditions are excluded, CIP is the leading disorder that causes respiratory muscle weakness.<sup>6,16,21,22</sup>

Pulmonary function tests, particularly negative inspiratory pressures, have been used commonly as a reliable guide for weaning by a pulmonologist. Their correlation to EMG parameters, however, has not been well-established in the EMG literature. Gouri-Devi M and associates<sup>28</sup> found a good correlation between phrenic nerve stimulation and vital capacity. The EMG, including neurophysiological testing of the respiratory system by studying the phrenic nerve function and intercostal or diaphragm muscles by needle examination,<sup>18</sup> not only can establish the diagnosis of CIP but can exclude other neuromuscular diseases.<sup>2,3,18,24</sup>

Differentiating CIP from other neuromuscular diseases that present with respiratory failure<sup>18,21,22</sup> is relatively straightforward if one follows the sequence of events leading to the development of CI. The axonal form of

GBS may be difficult to differentiate from CIP. Cerebral spinal fluid commonly shows elevation of protein,<sup>29</sup> and patients usually are weak before admission to the ICU.

### Summary

With increasing survival rates from acute medical or surgical emergencies a new form of peripheral neuropathy, CIP, has been recognized. CIP can be seen only in patients who are considered to be critically ill; therefore, it invariably occurs in the ICU. Typically, initial symptoms begin with transient (hours to a few days) septic encephalopathy followed by generalized weakness, manifested in weaning failure, limb weakness and hyporeflexia. Diagnosis is confirmed by an EMG.

CIP should be considered in any elderly patient with sepsis and prolonged respiratory muscle weakness. Prognosis is poor in severe cases, in which the EMG

also shows severe axonal degeneration. In milder forms, fair to good recovery is expected within weeks. Management includes treatment of sepsis, normalization of failing organ function, physical therapy and proper nutrition.<sup>30</sup> □

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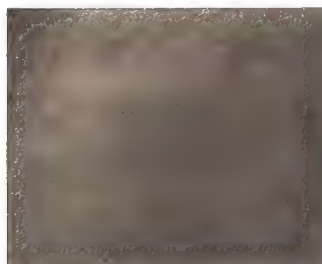


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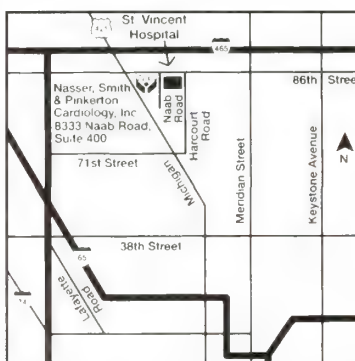


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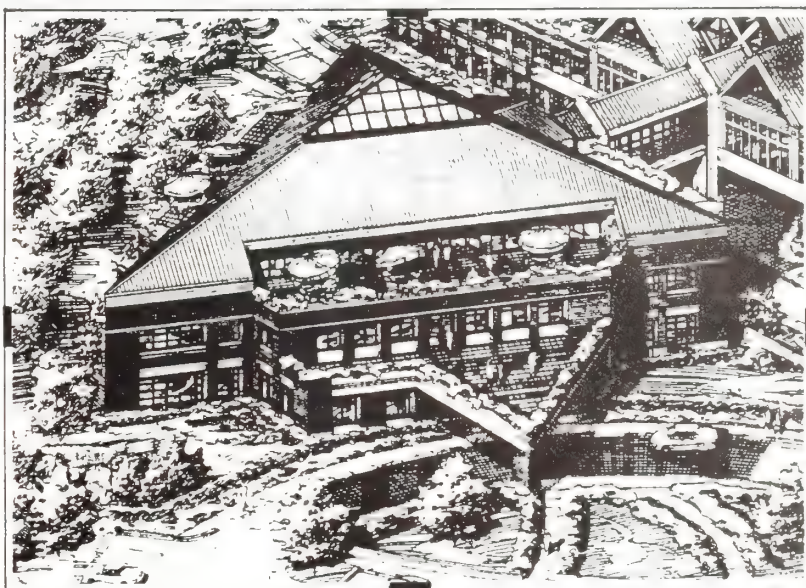
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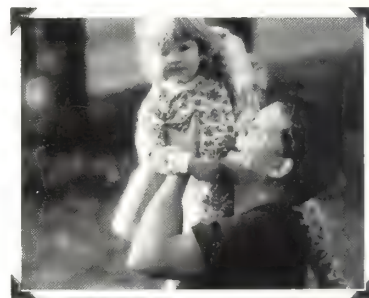
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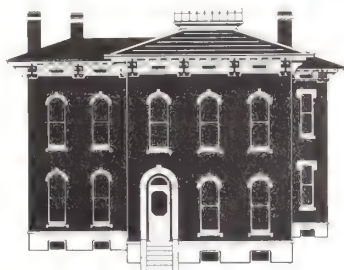
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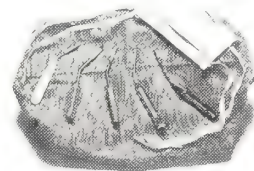


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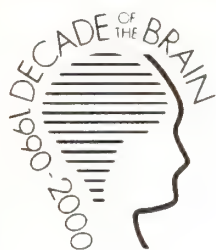
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## NEUROLOGICAL SURGERY



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## ■ alliance report

### Alliance state health project will help children handle conflict

**Darlene Haddawi**  
ISMA Alliance president

As part of the Alliance's effort to educate the public on the problems of violence in our communities, our efforts will now expand to teach children the right way to handle conflict. The "I Can Choose Workbook," published by the AMA Alliance, lets children know that they can make the right choices and that they can help make their world a safer place.

During March, National Alliance Month, and for Doctor's Day, March 30, county alliances will be asked to participate in the I Can Choose project by donating workbooks to grade K-3 communities. Workbooks are available from the AMA for \$34.95 for 100 copies. For more information call Sharon Gilmor, ISMA Alliance Health Promotion Chair, (317) 298-3412.

**ISMA/ISMA Alliance Family Violence Task Force**  
Information packets on family violence and referral resources were distributed at the ISMA House of Delegates and the ISMA Alliance Annual Convention. To receive a packet, call Janice Herring at the ISMA, 1-800-257-4762 or (317) 261-2060, or Alliance President Darlene Haddawi, (812) 339-9092.

#### Medicine Day

ISMA physicians and their spouses are encouraged to attend Medicine Day, Jan. 25, at the Hyatt Regency in Indianapolis. The day will begin with a continental breakfast and a legislative update by the ISMA legislative affairs staff, followed by a visit to the Statehouse to meet with legislators and attend committee hearings. Physicians and

their spouses will host their legislators during a luncheon at the Hyatt.

The ISMA Alliance will hold a state board meeting at 1:30 p.m. All ISMA physician spouses are invited to attend the meeting. AMA Alliance Legislative Chair Liz Kagan of Florida will give a national update on legislation concerning medicine, and Shirley Becker, ISMA Alliance legislation chair, will present a breakout session on county participation in legislative activities.

#### Confluence II

Confluence II, the AMA Alliance leadership training seminar for county officers will be held in

Chicago, Jan. 29 through 31.

Confluence II participants are Kim Beiser, Porter County; Sylvia Dulay, Vanderburgh County; Sandy Fox, Bartholomew-Brown County; Mary Lou Tenbrink, Vigo County; Margaret Grayson; Wayne-Union County; Joann Wehlage and Genelle King, St. Joseph County; and Ann Silberman, Porter County. Also attending will be Resident Spouse Valerie Huddleston of Delaware Blackford County; Adele Lash, ISMA communications director; Darlene Haddawi, ISMA Alliance president; Valerie Gates, ISMA Alliance president-elect; and Rosanna Iler, ISMA Alliance executive director. □



Sue Ellen Greenlee, ISMA Alliance immediate past president; Sharon Scott, AMA Alliance president-elect; and Darlene Haddawi, ISMA Alliance president, attended Presidents' Night Oct. 22 at the Westin Hotel during the ISMA annual convention.



# A MATTER OF LIFE OR DEATH?

## ASK YOURSELF:

- ☐ Will my Life Insurance policy pay me a cash benefit if I develop a critical illness and don't die?
- ☐ Will my Disability Income policy pay me a lump sum or monthly benefit if I almost become disabled from a critical illness?
- ☐ Will my Health Insurance policy pay me a cash benefit after I have been treated for a critical illness?

Your answer to all three questions is NO. That's because until now, no coverage has been available which would pay a lump sum benefit when you need it the most... when you SURVIVE a heart attack, cancer, stroke or other critical illness.

*67% of the 1.5 million people in the U.S. who suffer a heart attack each year survive and 50% survive for at least 13 years!*

*51% of the 1.2 million people in the U.S. that are diagnosed with cancer each year will survive at least 5 years!*

*70% of the 500,000 stroke victims in the U.S. each year will survive for at least one year!*

Though most people survive for a significant period after the diagnosis of a critical illness, their families' financial security may not.

A plan is now available through the ISMA which pays a lump sum benefit upon the diagnosis of:

- Critical Illness
- Permanent Disability or
- Death



For more information on this plan please contact your ISMA Benefit Representative at **1-800-442-ISMA.**

**SURVIVOR**  
**Key**

The key  
to protecting  
the quality of life  
in the event of  
critical illness.

## ■ from the museum

Oren S. Cooley  
Indianapolis

The discoveries about the nervous system during the 19th century significantly altered health care practices for athletes and societal perceptions about physical training as athletics increased in popularity from 1865 to 1906.

Physiology of the early 1800s had maintained that the brain served as the organ through which the immaterial mind received bodily sensations and, subsequently, issued the volitions that resulted in bodily movement. However, British anatomist Sir Charles Bell (1774-1842) discovered in the early 1800s that the anterior roots of the spinal nerves conveyed motor impulses while the posterior roots conveyed sensory impulses.

By the middle 1800s, the essentials of the nerve tract, with one terminal in a cell of the brain or spinal cord and the other terminal in the muscle or the skin, had been determined. Many contemporary physicians, physiologists, educators, social reformers and theologians began to espouse arguments that linked these new concepts with the traditional concepts of "the mind" and "the will."

However, Michael Foster, M.D., (1836-1907) in his *Textbook of Physiology* (1877) reflected the more scientific attitude that was emerging in medicine. Foster said the body was comprised of various tissues bound together by the vascular mechanism and the nervous coordinating mechanism. The latter was connected to the muscles, which in higher animal forms were arranged with the greatest precision to achieve the

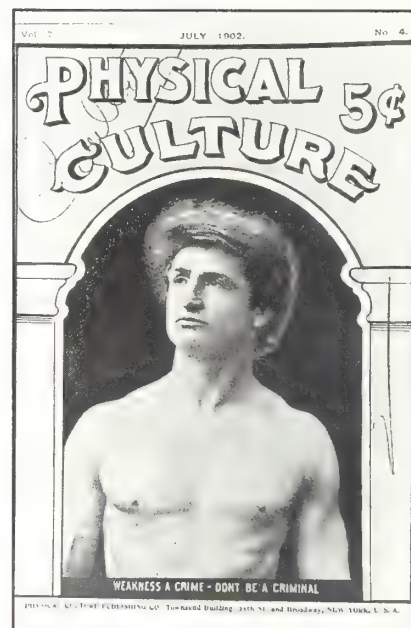
chief end of animal life – muscular movement.

These developments significantly impacted physical training and athletics, which experienced an immense popularity between 1865 and 1906. As society became more urbanized during this time, people in the upper and middle classes wanted more physical activity to alleviate any health problems perhaps caused by sedentary occupations.

The goals of physical training and athletics were hygienic as well as educative. In its concern with fitness and bodily health, the hygienic goal relied heavily on the biological sciences, especially the physiology of the circulatory, respiratory and digestive systems.

The educative goal of physical training and athletics focused on development, which included the ways in which character formed and the manner in which the human species evolved. As the new concepts of the nervous system and the brain emerged, a belief developed that the muscular action undertaken in athletics could contribute to strengthening the individual's – and therefore, society's – moral qualities.

Although the calisthenics and gymnastics popular after the Civil War could benefit the body (i.e., could achieve the hygienic goal), they did not have the cooperative element necessary to develop character (i.e., achieve the educative goal). As a result, the continuing interest in physical training and athletics prompted the emergence of athletic clubs, cooperative games and varsity sports by the 1890s. Requiring public spirit, self-subordination and cooperative effort, these team sports were perceived as possessing particular value for their moral effects. □



People expressed considerable interest in physical training and athletics during the late 1800s and early 1900s. The vitality, strength and body proportion stressed by physical culturist Bernarr Macfadden (1868-1955) in his early 20th century physique contests played upon this enthusiasm for physical fitness.

*The new exhibit on the history of sports medicine at the Indiana Medical History Museum explores not only the development of the field of sports medicine but also the techniques used to treat various sports-related injuries. The museum, located at 3045 W. Vermont, Indianapolis, is open from 10 a.m. to 4 p.m., Wednesday through Saturday, and other times and days by appointment by calling (317) 635-7329.*

*The author is director of the Indiana Medical History Museum.*

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 Shirley Khalouf, Marion (1996)  
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- 3 – Pres: Daniel Cannon, New Albany  
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 Annual Meeting: May 17, 1995
- 4 – Pres: Alan Kohlhaas, Lawrenceburg  
 Secy: Gerald Bowen, Lawrenceburg  
 Annual Meeting: May 3, 1995
- 5 – Pres: Warren Macy, Greencastle  
 Secy: Rahim Farid, Brazil  
 Annual Meeting: May 25, 1995
- 6 – Pres: Helen Steussy, New Castle  
 Secy: to be announced  
 Annual Meeting: May 10, 1995
- 7 – Pres: Craig Moorman, Franklin  
 Secy: John Schneider, Indianapolis  
 Annual Meeting: to be announced

- 8 – Pres: Kathleen A. Galbraith, Portland  
 Secy: Mark A. Haggengos, Portland  
 Annual Meeting: June 7, 1995
- 9 – Pres: Herschell Servies, Lebanon  
 Secy: Stephen D. Tharp, Frankfort  
 Annual Meeting: June 14, 1995
- 10 – Pres: Frank Hieber, Munster  
 Secy: Floyd Manley, Hammond  
 Annual Meeting: April 29, 1995
- 11 – Pres: to be announced  
 Secy: Jack Higgins, Kokomo  
 Annual Meeting: Sept. 13, 1995
- 12 – Pres: Joseph Manthey, Liberty Center  
 Secy: David Haines, Warsaw  
 Annual Meeting: Sept. 14, 1995
- 13 – Pres: Donald Smith, South Bend  
 Secy: John W. Schurz, South Bend  
 Annual Meeting: March 22, 1995

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# ■ cme calendar

## PICI Preferred Risk Seminar

The Physicians Insurance Company of Indiana (PICI) will present its 1995 Preferred Risk Loss Prevention seminar on liability issues related to managed care on the following dates and locations:

- Mar. 1 - Fort Wayne
- Mar. 2 - New Castle
- Mar. 8 - Merrillville
- Mar. 9 - Michigan City
- Mar. 14 - Indianapolis
- Mar. 16 - Lafayette
- Mar. 21 - Seymour
- Mar. 22 - Evansville
- Mar. 23 - Terre Haute
- Mar. 28 - Bloomington

The program will be presented from 7 p.m. to 8:30 p.m. PICI designates this continuing medical education activity for 1.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For more information, call the PICI Risk Management Dept. at 1-800-284-7424. PICI policyholders who attend will receive a 5% premium discount on their next policy renewal.

## Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology Inc. will present the following CME courses in 1995:

- Mar. 10 - Echocardiography 1995, Ritz Charles, Indianapolis.
- Apr. 28 - Progress in Cardiology VIII, Westin Hotel, Indianapolis.
- Aug. 23 - Practice Management Seminar, Ritz

Charles, Indianapolis.

- Nov. 3 - Emergency Physician Seminar, Ritz

Charles, Indianapolis

For registration information, call Janet MacAbee at (317) 338-6089.

## St. Mary's Medical Center

St. Mary's Medical Center in Evansville will present "G.I. Cancer Screening" March 2 in the center's amphitheatre.

For more information, call the CME office at (812) 479-4468.

## University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Mar. 2-4 - Advances in the Management of Infectious Diseases: Winter Update, South Seas Plantation, Captiva Island, Fla.

- Mar. 15-17- A Symposium in Diabetes Care, Towsley Center, Ann Arbor, Mich.

- Mar. 21-25- Family Practice 1995 - 19th Annual Spring Review Course, Towsley Center, Ann Arbor, Mich.

- Mar. 30-31- Challenges and Changes in Obstetrics and Gynecology, Towsley Center, Ann Arbor, Mich.

- Apr. 1 - Transvaginal Ultrasound Workshop, Towsley Center, Ann Arbor, Mich.

- Apr. 5-7 - Ultrasound in Obstetrics and Gynecology, Towsley Center, Ann Arbor, Mich.

- Apr. 6-9 - The Multimodality Treatment of Breast Cancer, Pinehurst Resort and Country Club, Pinehurst, N.C.

For registration information, call Vivian Woods at (313) 763-1400.

## University of Wisconsin

The University of Wisconsin School of Medicine will present "Low Intervention Obstetrics" April 20 and 21 at the Concourse Hotel in Madison, Wis.

Physicians, nurses, physician assistants and other health professionals are invited to attend.

For more information, call Sarah Aslakson, (608) 263-2856. □

## How to submit CME news

To publish news of your CME courses, mail information to Indiana Medicine, 322 Canal Walk, Indianapolis, IN 46202-3268 or fax it to (317) 261-2076. News is due two months before publication (e.g., Jan. 20 for the March/April issue). □

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## ■ news briefs

### **Grant provides funding for state AIDS prevention**

The Health Foundation of Greater Indianapolis and the Indiana State Department of Health have received one of five AIDS Services/Prevention Grants from the National Community AIDS Partnership.

The grant could provide up to \$425,000 for the fight against AIDS in Indiana. With local matching requirements, the initiative could trigger nearly \$900,000 of new funding for AIDS prevention and services in Indiana. First-year funding of \$25,000 will be used to convene local AIDS leaders, conduct a needs assessment, build a comprehensive plan and develop a funding strategy. Subsequent-year funding will be used to match local contributions raised to implement the plan.

The Health Foundation of Greater Indianapolis, created in 1985 with proceeds from the sale of Indiana's first health maintenance organization, has become the largest private-sector funder for HIV/AIDS prevention and care programs in central Indiana. Since 1989, the organization has contributed more than \$4.5 million to health-related projects that are not easily funded by other means.

### **ISDH gets grant to start data program**

The Indiana State Department of Health received a \$200,000 grant from the Centers for Disease Control and Prevention to develop an innovative and comprehensive data program.

The grant will help the ISDH develop a comprehensive data architecture and information

system to track health care access, quality and cost-effectiveness. The Indiana project will include the development of a statewide health data system using regional "hubs." Data drawn from the hubs will allow rational tracking of important population-based health information, such as immunization status and infant mortality rates.

### **St. Vincent Hospital offers surgical fellowship**

Surgeons are eligible to apply for a one-year fellowship in surgical laparoscopy, endoscopy and ultrasound at St. Vincent Hospital in Indianapolis.

Interested physicians may send letters of inquiry with their curriculum vitae to the director of the program, Maurice E. Arregui, M.D., 8402 Harcourt Road, Suite 811, Indianapolis, IN 46260. Applications are currently being accepted for July 1995.

### **John Shaw Billings Society lists programs**

The John Shaw Billings History of Medicine Society at the Indiana University Medical Center has announced upcoming programs.

Lois Magnier, Ph.D., of the history department at Purdue University, will speak on "A License to Learn: Medical Education and Professionalization" Feb. 27.

P. Michael Conneally, Ph.D., distinguished professor of medical genetics and neurology at the IU Medical Center, will speak on "History of Medical Genetics at Indiana University" at the March program. A date has not been confirmed.

Both programs will be at 4

p.m. in the Ruth Lilly Medical Library, Room 301-302.

### **New AMA service offers discounted supplies**

Henry Schein Inc. and AMA Resources Inc. have launched AMA Purchase Link, a purchasing savings program designed to reduce the operating costs of office-based physicians.

Through AMA Purchase Link, Henry Schein will offer physicians pharmaceuticals, vaccines, diagnostic tests, exam room supplies, instruments and surgical dressings. Benefits for members include savings up to 40% on the most frequently used products, discounts on every item in the Henry Schein medical catalog, free shipping for AMA members, orders shipped the same or next day for most items and no membership fees or minimum orders.

For more information about Purchase Link, call AMA Resources at 1-800-422-0077 from 8:30 a.m. to 4:30 p.m., Central Time, Monday through Friday.

### **Applications available for diabetes research grants**

The Juvenile Diabetes Foundation International has announced the availability of grants in diabetes research for the funding year Sept. 1, 1995, to Aug. 31, 1996.

Applications may be obtained from Grant Administrator, Juvenile Diabetes Foundation International, 432 Park Ave. South, Suite 206, New York, NY 10016, (212) 889-7575. Completed applications must be received by March 1. One copy of the first two pages of the application must be received by Feb. 15. □



### **Robert E. Beck, M.D.**

Dr. Beck, 68, an Evansville radiologist, died Oct. 22, 1994, at Deaconess Hospital.

He was a 1949 graduate of the Indiana University School of Medicine and a Navy veteran.

Dr. Beck was director of the radiology department at Deaconess Hospital and an associate at Evansville Radiological Association.

### **Rodney C. Caudill, M.D.**

Dr. Caudill, 71, a retired Muncie psychiatrist, died Oct. 25, 1994.

He was a 1948 graduate of the Ohio State University College of Medicine and an Air Force veteran.

Dr. Caudill had been a psychiatric consultant for Aquarius House at Ball State University and the Family Practice Residents Program at Ball Memorial Hospital. He also founded and was director of the Meramec Psychiatric Center in Yorktown in 1970. He retired in 1975.

### **Forrest E. Keeling, M.D.**

Dr. Keeling, 97, a retired Portland pediatrician, died Oct. 17, 1994, at Four Seasons Health Center in Columbus.

He was a 1923 graduate of the Indiana University School of Medicine and an Army veteran of World War I and World War II. During the Korean conflict, he was sent to Germany to train and activate the 2nd Evacuation Hospital.

Dr. Keeling served twice as Jay County Hospital chief of staff. During the polio epidemic of 1949, he and other physicians established a temporary hospital at the Portland American Legion. He was Jay County coroner from 1928 to

1934. He retired in 1978, after 50 years of practice in Portland.

### **Carl D. Martz, M.D.**

Dr. Martz, 80, a retired Indianapolis orthopaedic surgeon, died Oct. 26, 1994, in Punta Gorda, Fla.

He was a 1940 graduate of the Indiana University School of Medicine.

Dr. Martz was a surgeon 37 years and served on the staffs of several Indianapolis hospitals. He was professor emeritus in orthopaedics at the IU School of Medicine, where he began teaching in 1942. He was director of the Cerebral Palsy Clinic at Riley Hospital and director of emergency services at Wishard Hospital in Indianapolis. He served on the disaster committees of Presidents Kennedy and Johnson.

### **William L. Sharp, M.D.**

Dr. Sharp, 88, a retired Anderson psychiatrist, died Sept. 24, 1994, at Willows Convalescent Center in Alexandria.

He was a 1930 graduate of the Indiana University School of Medicine. He was a U.S. Army veteran, serving as division psychiatrist for the 99th Infantry Division in the European theater in World War II. He received the Bronze Star for meritorious service in combat for his work in screening all neuropsychiatric casualties.

Dr. Sharp had served as chief of psychiatry at St. John's Medical Center for 50 years and as health officer for Madison County. He was board certified and one of the first psychiatrists to practice in Anderson. He retired in 1987.

### **Roy M. Smith, M.D.**

Dr. Smith, 65, an Evansville family physician, died Aug. 23, 1994, at

Deaconess Hospital in Evansville.

He was a 1953 graduate of the Indiana University School of Medicine and an Air Force veteran.

Dr. Smith practiced in the Evansville area for 41 years and was on the staffs of Deaconess Hospital and St. Mary's Medical Center. He was president of the Deaconess Hospital medical staff in 1967.

### **Carl F. Stallman Jr., M.D.**

Dr. Stallman, 75, a Kendallville family physician, died Sept. 10, 1994, at Lutheran Hospital in Fort Wayne.

He was a 1951 graduate of the Indiana University School of Medicine. He was an Army veteran of World War II and earned a Silver Star and the rank of lieutenant.

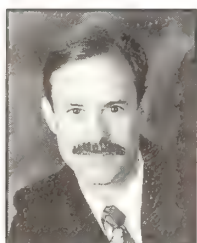
Dr. Stallman had practiced in Kendallville since 1952.

### **Billy D. Wagoner, M.D.**

Dr. Wagoner, 70, a Carmel family physician, died Nov. 2, 1994.

He was a 1951 graduate of the Indiana University School of Medicine. He was an Army Air Forces veteran of World War II and an Air Force veteran of the Korean War.

Dr. Wagoner had been a family practice physician in Union City for 27 years and in the Indianapolis and Carmel areas for 14 years. He had been director of Emergency Physicians Inc. of Reid Memorial Hospital in Richmond eight years, retiring in 1983. He was a life member of the American Academy of Family Physicians and charter director of the Indiana Chapter of the American College of Emergency Physicians. □



**Dr. Francis W. Price Jr.**, an Indianapolis ophthalmic surgeon, will be the chief medical monitor for all U.S. trials of a

**Dr. Price** new glaucoma surgery technique developed at Russia's Fyodorov Clinic in Moscow. He is co-director of Corneal Consultants of Indiana in Indianapolis and Fort Wayne. The technique, according to Dr. Price, uses a smaller incision than commonly used as well as the implantation of a collagen insert in the eye for improved postoperative drainage control.

**Dr. Hill Hastings II** of the Indiana Hand Center in Indianapolis received two awards at the annual meeting of the American Society for Surgery of the Hand in Cincinnati. He



**Dr. Hastings** shared the awards with Dr. Carlos Zaidenberg of Buenos Aires, Argentina. This was the first time any author has won two awards at the same meeting. They received the Sumner L. Koch Award from the Chicago Society for Surgery of the Hand for the presentation with the "greatest future clinical application to the practice of hand surgery." In addition, they received the Emanuel B. Kaplan Award from the New York Society for Surgery of the Hand for the presentation judged to represent

## Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

### September 1994

Baker, Mason R., Evansville  
Boling, Grover C., Indianapolis  
Douglas, Brian C., Zionsville  
Fitzpatrick, Michael S., Jeffersonville  
Foster, Lowell G., Indianapolis  
Jones, Mark C., Evansville  
Kerner, Donald J., Beech Grove  
King, Dennis E., Vincennes  
Morrison, Andrew L., Indianapolis  
Parker, E. Camille K., Logansport  
Poulos, James T., Lafayette  
Price, Francis W., Indianapolis  
Rathbun, John M., Fort Wayne  
Sood, Rajiv, Carmel  
Suwan, S., Merrillville  
Tower, James H., Shelbyville  
West, Samuel L., Michigan City

### October 1994

Brillhart, James R., Indianapolis

Burk, David A., Greenfield  
Carnes, John D., Huntington  
Cavins, John A., Indianapolis  
De Palma, Bruno, Lawrenceburg  
Diotallevi, Gary H., Newburgh  
Fiscus, Clifford W., Indianapolis  
Fulton, William H., Indianapolis  
Gordon, Irene M., Lafayette  
Guthrie, James U., Peru  
Hanke, C. William, Indianapolis  
Lawrence, James M., Indianapolis  
McPike, Joseph D., Indianapolis  
Miller, Jean C., Indianapolis  
Miller, William J., Lafayette  
Min, Kun K., Munster  
Morrissey, Alonzo K., Munster  
Nasr, Amin T., Muncie  
Sevier, Thomas L., Muncie  
Shugart, Robert R., Fort Wayne  
Steele, Robert J., Kokomo  
Stransky, Theodore J., Evansville  
Welch, Anna L., Lafayette

"anatomical excellence in surgery of the hand." The awards were given for their work on "Vascularized Distal Radius Bone Grafts." Dr. Hill also was chairman of the surgical skills course on "Vascularized Bone Grafts for Carpal Reconstruction."



**Dr. Strickland**

Georgia Society for Surgery of the Hand in Sea Island, Ga. He talked on "Surgery for the Rheumatoid

**Dr. James W. Strickland** of the Indiana Hand Center in Indianapolis was the President's Guest Speaker at the annual meeting of the

Wrist." He was a guest speaker at the Georgia Orthopaedic Association annual meeting, where he gave an update on the American Academy of Orthopaedic Surgeons Public Awareness Program.



**Dr. Capicotto**

Term Follow-Up" at the 1994 North American Spine Society

**Dr. Peter N. Capicotto** of The Spine Institute in Beech Grove presented a paper on "Operative Treatment of Recurrent Lumbar Disk Herniations with Mid-



Meeting in Minneapolis.

**Dr. Todd Dudley** and **Dr. James Gahimer** have opened an



**Dr. Dudley**



**Dr. Gahimer**

internal medicine practice on the St. Francis Hospital South Campus, 8141 S. Emerson Ave., Indianapolis. Both are board certified and graduates of the Indiana University School of Medicine.

Accomplishments and achievements of physicians at Nasser, Smith & Pinkerton Cardiology in Indianapolis include the following: **Dr. William K. Nasser** received the Otis R. Bowen, M.D., Distinguished Leadership Award at the Scottish Rite Cathedral in Indianapolis. **Dr. Borys Surawicz** published a textbook titled *Electrophysiologic Basis of ECG and Cardiac Arrhythmias*. Dr. Surawicz was a keynote speaker at the annual meeting of the Japanese Society of Electrocardiology in Matsue, Japan; his topic was "Rate-Dependent Refractoriness of Heart Muscle." **Dr. John D. Slack** presented a poster at the American Heart Association's Scientific Sessions in Dallas; the poster was titled "Use of 5 French Catheters for Elective Outpatient Cardiac Catheterization: Minimal Early and Late Access Site Bleeding Despite Early Ambulation Protocol." **Dr. James B. Hermiller** spoke on "Late Lesion Regression Within the Gianturco-Roubin Flex Stent"

and **Dr. Edward T. A. Fry** spoke on "Gianturco-Roubin Stenting for Failed PTCA of Bypass Grafts" at the American Heart Association's Scientific Sessions in Dallas. **Dr. Charles M. Orr** spoke on "Congestive Heart Failure: New Drugs and Treatment" at a meeting of the Indiana Academy of Family Physicians. **Dr. Nancy Branyas** spoke on "Mechanisms and Treatment of AV Node Re-entry and WPM" at a meeting of the Indiana Society for Pacing and Electrophysiology.

Accomplishments and achievements of physicians at Orthopaedics Indianapolis include the following: **Dr. David A. Fisher** discussed "Depuy's Anatomic Medullary Locking System as a Total Hip System" on the Discovery Channel's "Cutting Edge Medical Report." **Dr. Sanford S. Kunkel** was the author of a section on "Basketball Injuries and Rehabilitation" in *Sports Medicine and Rehabilitation - A Sport-Specific Approach*. **Dr. Kevin Scheid** presented a program on "Subtrochanteric Femur Fractures" at a trauma management course at Louisiana State University and a program on "Acetabular Fractures" at Washington University Medical Center in St. Louis. **Dr. David M. Kaehr** presented "Internal Fixation of the Foot and Ankle" and "Tension Band Principal" at the A-O Operating Room Personnel Course in Cincinnati.

Accomplishments and achievements of physicians at Northside Cardiology in Indianapolis include the following: **Dr. Daniel Lips** and **Dr. Scott Sharp**, of Southside Cardiology, a division of Northside Cardiology, were elected fellows of the American College of Cardiology. **Dr. Donald Rothbaum** was a guest

speaker at the Chattanooga Unit of the University of Tennessee College of Medicine and Erlanger Medical Center; his speech was titled "PTCA in Acute Infarction After PAMI."

**Dr. Ivan Lindgren**, a family physician in Aurora, was re-appointed to a four-year term as Dearborn County Health Officer. He has held the position since 1971.

**Dr. Barbara K. Siwy**, an Indianapolis plastic and reconstructive surgeon, participated in a panel discussion at the Reach to Recovery Biennial, held in Indianapolis and sponsored by the American Cancer Society, Indiana Division. Her topic was immediate breast reconstruction.

**Dr. Alan T. Marty** of Cardiovascular Surgery in Evansville received the Alfred Soffer Award for Editorial Excellence from the American College of Chest Physicians. He serves on the editorial boards of several medical journals and has published more than 200 scientific articles and book reviews. Only two other individuals have been so honored.

**Dr. Clifford W. Fiscus**, an Indianapolis ophthalmologist, lectured and performed ophthalmic surgery in the Russian Far East. Cataract surgery with uveitis and treatment of glaucoma were topics of discussions and lectures during meetings with Russian surgeons in Blagoveshchensk and Khabarovsk.

**Dr. Olaf Johansen** of Mooresville was appointed to a three-year term as cancer liaison physician for the Hospital Cancer Program at Kendrick Hospital in Mooresville.

**Dr. Maurice Arregui**, an Indianapolis surgeon, gave a talk on "Laparoscopic Ultrasound



## ■ people

Versus Intraoperative Cholangiography in Laparoscopic Cholecystectomies" during the postgraduate course on minimally invasive surgery at the meeting of the American College of Surgeons in Chicago. He was named state chairman and board member of the Society of American Gastrointestinal Endoscopic Surgeons.

**Dr. Steven Ahlfeld** of Indianapolis was a panelist for a symposium on basketball injuries held during the annual meeting of the American College of Sports Medicine in Indianapolis.

**Dr. Stephen W. Perkins**, of Meridian Plastic Surgery Center in Indianapolis, was co-director of the seminar on "Current Controversies, Concepts and Techniques in Facial Plastic Surgery" sponsored by the Indiana University School of Medicine. He led four seminars, including discussions of "Comparison of Perioral Dermabrasion and Chemical Peel" and "Rejuvenation of the Glabella and Brow"; moderated a panel discussion on "Controversial Issues in Management and Modalities in Dermatologic and Laser Surgery"; and served as a panelist on a discussion of "Controversies in Aging Face Surgery." His colleagues at the surgery center, **Dr. John Coleman III** and **Dr. A. Michael Sadove**, led a seminar on "Diagnosis and Management of Congenital and Acquired Facial Asymmetries: Soft Tissue and Skeletal Reconstruction." Dr. Coleman also was a panelist for a discussion on "Controversies on Skeletal Facial Surgery, and Dr. Sadove was a panelist on discussions of "Controversial Issues in Management and Modalities in Dermatologic and Laser Surgery" and "Controversies in Aging Face Surgery." **Dr. Robert J. Havlik**,

another member of the surgery center staff, led a seminar on "Treatment of Telecanthus and Hypertelorism."

**Dr. Daniel H. Spitzberg**, a Carmel ophthalmologist, was elected chairman of the ophthalmology department at Methodist Hospital in Indianapolis.

**Dr. Steven F. Isenberg**, an Indianapolis otorhinolaryngologist, spoke on "Project Solo - A National Database" during a meeting of the practice management and research committee at the annual meeting of the American Academy of Otolaryngology - Head and Neck Surgery in San Diego. After his presentation to the AAO-HNS board of directors, the academy voted to unanimously endorse the concept of Project Solo. An article written by Dr. Isenberg on "Endoscopic Approach to the Diagnosis of Fibrous Dysplasia" was published in the November issue of *ENT Journal*.

**Dr. William Beeson**, an Indianapolis facial plastic and reconstructive surgeon, was an instructor for the Endoscopic Facial Surgery Seminar at the University of California-San Diego. He gave an update on dermabrasion and laser abrasion at the annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery. He was a guest lecturer and instructor for a laser symposium in Santa Barbara, Calif.; his topics included "Tissue Effects of Laser Hair Transplantation," "Laser Resurfacing: Efficacy and Tissue Effects Study" and "High Output Pulsed CO<sub>2</sub> Laser Blepharoplasty and Trans-Blepharoplasty Brow Suspension."

**Dr. James Trippi**, an Indianapolis cardiologist, and his family received the 1994 Archbishop

Edward T. O'Meara Respect Life Award for "faith-filled and tireless work on behalf of the church's concern for the value of human life." Dr. Trippi and his wife, Linda, were honored for their community service as the founders of the Gennesaret Free Clinic, a seven-year-old volunteer organization which provides free health care and medicine to homeless and indigent people in Indianapolis.

**Dr. T. Kermit Tower** of Campbellsburg was honored at a dinner hosted by the Washington County Division of the American Heart Association. He has been a practicing physician in Washington County for 58 years and served on the school board for 43 years.

**Dr. Robert M. LaSalle** has retired after 36 years as a family physician in Wabash.

**Dr. Joseph J. Zore**, a Richmond pediatrician, received the 1994 Paul S. Rhoads Humanity in Medicine Award at Reid Hospital in Richmond. □

### New ISMA members

**Troy A. Abbott, M.D.**, Muncie, family practice.

**Mary Ann Sprauer Abrams**, M.D., Indianapolis, pediatrics.

**Frederick H. Albrink, M.D.**, Jeffersonville, radiation oncology.

**Henry M. Andoh, M.D.**, Munster, infectious diseases.

**Robert B. Avena, M.D.**, Sullivan, internal medicine.

**Joseph Baylor, M.D.**, Evansville, obstetrics and gynecology.

**Eric G. Beier, M.D.**, Fort Wayne, emergency medicine.

**Gayle J. Borkowski, M.D.**, Angola, obstetrics and gynecology.

**Benny S. Buslon, M.D.**, Logansport, anesthesiology.

**Kenneth D. Calhoun, M.D.**, Evansville, family practice.

**John C. Cherukara, M.D.**, Fort

Wayne, anesthesiology.

**Kenneth G. Combs, M.D.,**  
Newburgh, internal medicine.

**Keith B. Danckaert, M.D.,** Fort  
Wayne, dermatology.

**Ludo F.M. DeKeyser, M.D.,**  
Munster, diabetes.

**Mary T. Degeneffe, M.D.,**  
South Bend, pediatrics.

**Anuradha Divakaruni, M.D.,**  
Munster, cardiovascular diseases.

**James S. Dunnick, M.D.,**  
Evansville, cardiovascular dis-  
eases.

**Brenda L. Eriksen, M.D.,**  
Hammond, anatomic/clinical  
pathology.

**Emmanuel B. Favila, M.D.,**  
Terre Haute, cardiovascular  
diseases.

**Alexander Ferenczy, M.D.,**  
Lafayette, emergency medicine.

**John W. Fleming II, M.D.,**  
Shelbyville, family practice.

**Lisbeth A. Gallagher, M.D.,**  
Chicago, anatomic/clinical pathol-  
ogy.

**S. Aurora Gardner, M.D.,**  
Connersville, family practice.

**Ruben B. Gonzales, M.D.,**  
Terre Haute, internal medicine.

**Eric D. Gourieux, M.D.,**  
Evansville, family practice.

**Narendra K. Gupta, M.D.,**  
Logansport, internal medicine.

**Dennis P. Han, M.D.,**  
Valpraiso, otolaryngology.

**Steven A. Hanberg, M.D.,**  
Elkhart, internal medicine.

**James N. Hawkins, D.O.,**  
Huntingburg, obstetrics and  
gynecology.

**David K. Hirsh, M.D.,** Muncie,  
ophthalmology.

**Michael K. Hodkin, M.D.,**  
Muncie, ophthalmology.

**Evan B. Hurst, M.D.,** Jasper,  
internal medicine.

**Ghassan Jano, M.D.,** Munster,  
hematology.

**Ian Johnston, M.D.,** India-

napolis, obstetrics and gynecology.

**Thomas I. Jones, M.D.,**  
Lafayette, oncology.

**Barbara A. Kamer-Thompson,**  
M.D., Jeffersonville, obstetrics and  
gynecology.

**George S. Kouns, D.O.,** West  
College Corner, general practice.

**Karen A. Kovalow-St. John,**  
M.D., Michigan City,  
rheumatology.

**Richard A. Krizmanich, D.O.,**  
Valparaiso, anesthesiology.

**Evan L. Lehman, M.D.,**  
Marion, obstetrics and gynecology.

**Thomas D. Magill, M.D.,**  
LaPorte, orthopaedic surgery.

**Nghia T. Mai, M.D.,** Carlisle,  
family practice.

**David I. Malitz, M.D.,** Evans-  
ville, ophthalmology.

**Robert Mandel, M.D.,**  
Connersville, anesthesiology.

**Mitchell Mazurek, M.D.,**  
Merrillville, physical medicine and  
rehabilitation.

**Rodney S. Merrill, D.O.,**  
Merrillville, obstetrics and gyne-  
cology.

**A. Michael Moheimani, M.D.,**  
Shelbyville, orthopaedic surgery.

**Raymond S. Nanko, M.D.,**  
Muncie, family practice.

**J. Michael Neahring, M.D.,**  
Evansville, cardiovascular dis-  
eases.

**Jayest P. Patel, M.D.,** Fort  
Wayne, pediatrics.

**Pradip D. Patel, M.D.,** Terre  
Haute, cardiovascular diseases.

**Sudha P. Patel, M.D.,**  
Jasonville, internal medicine.

**Jude J. Perez, M.D.,** Evans-  
ville, emergency medicine.

**Devi K. Pierce, M.D.,**  
Corydon, internal medicine.

**Edward O. Reece, D.O.,**  
Lawrenceburg, obstetrics and  
gynecology.

**Crystal D. Reed, M.D.,** Evans-  
ville, diagnostic radiology.

**Michael J. Reilly, M.D.,**  
Greenfield, family practice.

**George S. Samson, M.D.,**  
Terre Haute, anesthesiology.

**Joseph F. Schwartz, M.D.,**  
Gary, orthopaedic surgery.

**Thomas E. Sehlinger, M.D.,**  
Jeffersonville, orthopaedic surgery.

**Alka Y. Shah, M.D.,**  
Merrillville, neurology.

**Hugh M. Sims III, M.D.,**  
Evansville, otolaryngology.

**Surjit Singh, M.D.,** Terre  
Haute, psychiatry.

**Geetha Sivam, M.D.,**  
Schererville, pediatrics.

**Christopher L. Sneed, M.D.,**  
Evansville, neurological surgery.

**Olive M. Soriero, M.D.,**  
Indianapolis, gynecological  
oncology.

**Thomas R. Stibbins, M.D.,**  
Jeffersonville, anesthesiology.

**Mani N. Sury, M.D.,** Kokomo,  
internal medicine.

**Lori S. Swan, M.D.,** Lafayette,  
dermatology.

**Ngoc Tran, M.D.,** Terre Haute,  
family practice.

**James E. Turk, D.O.,**  
Valparaiso, otolaryngology.

**Gary S. Ulrich, D.O.,** Terre  
Haute, orthopaedic surgery, sports  
medicine.

**Venkatarao Vemula, M.D.,**  
Fort Wayne, anesthesiology.

**Jeffrey A. Wheeler, M.D.,**  
Indianapolis, internal medicine.

**Robert L. Winders, M.D.,**  
Muncie, anesthesiology.

**Theresa A. Woods, M.D.,**  
Lafayette, pediatrics.

**Bruce R. Yalowitz, M.D.,**  
Merrillville, urological surgery.

**Martha Yearsley, M.D.,** Jasper,  
internal medicine.

**Alexander Zemtsov, M.D.,**  
Muncie, dermatology.

**Christopher M. Ziebell, M.D.,**  
Muncie, emergency medicine. □



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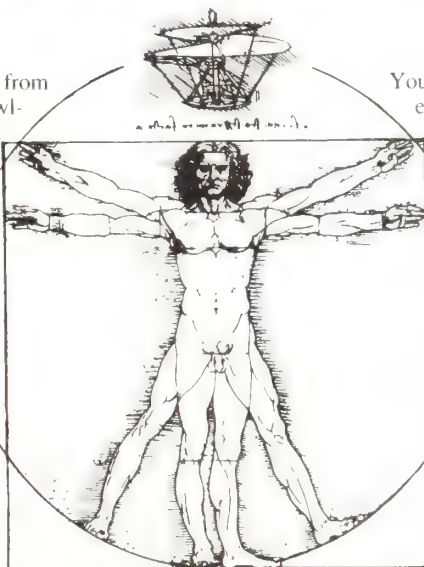
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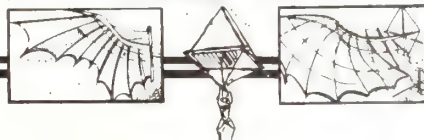
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## VOLTAREN®

diclofenac sodium  
Delayed-Release (enteric-coated) Tablets

## CATAFLAM®

diclofenac potassium  
Immediate-Release Tablets

**Brief Summary (For full Prescribing Information, see Package Insert.)**

### INDICATIONS AND USAGE

Voltaren Delayed-Release or Cataflam Immediate-Release Tablets are indicated for the acute and chronic treatment of signs and symptoms of rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis. Only Cataflam is indicated for the management of pain and primary dysmenorrhea when prompt pain relief is desired, because it is formulated to provide earlier plasma concentrations of diclofenac (see CLINICAL PHARMACOLOGY, Pharmacokinetics and Clinical Studies).

### CONTRAINDICATIONS

Diclofenac is the formulation Voltaren or Cataflam is contraindicated in patients with hypersensitivity to diclofenac. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactoid-like reactions to diclofenac have been reported in such patients.

### WARNINGS

#### Gastrointestinal Effects

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac, even in the absence of previous GI tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

**Risk of GI Ulcerations, Bleeding, and Perforation with NSAID Therapy:** Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous GI tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper GI ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal GI events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions; however, controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity.

#### Hepatic Effects

As with other NSAIDs, elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [= the Upper Limit of the Normal range]) or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 47 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Based on this experience, if diclofenac is used chronically, the first transaminase measurement should be made no later than 8 weeks after the start of diclofenac treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., esophagitis, gastritis, rash, etc.), diclofenac should be discontinued.

To minimize the possibility that hepatic injury will become severe during transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action patients should take if these signs and symptoms appear.

### PRECAUTIONS

#### General

**Allergic Reactions:** As with other NSAIDs, allergic reactions including anaphylaxis have been reported with diclofenac. Specific allergic manifestations consisting of swelling of eyelids, lips, pharynx, and larynx, urticaria, asthma, and bronchospasm, sometimes with a concomitant fall in blood pressure (severe anaphylaxis) have been observed in clinical trials and/or the marketing experience with diclofenac. Anaphylaxis has rarely been reported from foreign sources. In U.S. clinical trials with diclofenac in over 6000 patients, 1 case of anaphylaxis was reported. In controlled clinical trials, allergic reactions have been observed at an incidence of 0.5%. These reactions can occur without prior exposure to the drug.

**Fluid Retention and Edema:** Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

**Renal Effects:** As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of renal toxicity was noted. Isolated moments of papillary necrosis were observed in a few animals at high doses (10-120 mg/kg) in several baboon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those followed by impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

**Porphyria:** The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

#### Information for Patients

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

#### Laboratory Tests

Because serious GI tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, Risk of GI Ulcerations, Bleeding, and Perforation with NSAID Therapy). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac, these symptoms may become evident between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects).

#### Drug Interactions

**Aspirin:** Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

**Anticoagulants:** While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised. Nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with any NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

**Digoxin, Methotrexate, Cyclosporine:** Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be

monitored.

**Lithium:** Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

#### Oral Hypoglycemics

Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experience of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic events have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

**Diuretics:** Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

**Other Drugs:** In small groups of patients (7-10, interaction study), the concomitant administration of azathioprine, codeine, chloroquine, d-penicillamine, prednisolone, doxycycline, or digoxin did not significantly affect the peak levels and AUC values of diclofenac.

#### Protein Binding

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlorfentanyl, doxycycline, cephalexin, erythromycin, and sulfamethoxazole have no influence in vitro on the protein binding of diclofenac in human serum.

#### Drug/Laboratory Test Interactions

**Effect on Blood Coagulation:** Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma thrombin, or factors V and VII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree; therefore, patients who may be adversely affected by such an action should be carefully observed.

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day or 12 mg/m<sup>2</sup>/day (approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m<sup>2</sup>/day) female rats; high-dose females had excessive mortality, but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m<sup>2</sup>/day) in males and 1 mg/kg/day (3 mg/m<sup>2</sup>/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in *in vitro* point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian *in vitro* and *in vivo* tests, including dominant lethal and male germ cell chromosomal studies in mice, and nucleic acid and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m<sup>2</sup>/day) did not affect fertility.

#### Teratogenic Effects

There are no adequate and well-controlled studies in pregnant women. Diclofenac should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus.

#### Pregnancy Category B

Reproduction studies have been performed in mice given diclofenac sodium up to 20 mg/kg/day or 60 mg/m<sup>2</sup>/day and in rats and rabbits given diclofenac sodium up to 10 mg/kg/day or 60 mg/m<sup>2</sup>/day for rats and 80 mg/m<sup>2</sup>/day for rabbits, and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

#### Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, it is possible that diclofenac may inhibit uterine contractility.

#### Nursing Mothers

Diclofenac has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, diclofenac is not recommended for use in nursing women.

#### Pediatric Use

Safety and effectiveness of diclofenac in children have not been established.

#### Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

### ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results, rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In a 6-month, double-blind trial comparing Voltaren Delayed-Release Tablets (N=197) to Cataflam Immediate-Release Tablets (N=196) vs. ibuprofen (N=197), adverse reactions were similar in nature and frequency. In 718 patients treated for shorter periods, i.e., 2 weeks or less, with Cataflam Immediate-Release Tablets, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods.

The incidence of common adverse reactions greater than 1% is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with Voltaren Delayed-Release Tablets. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3% of patients. Peptic ulcer or GI bleeding occurred in clinical trials in 0.6% (95% confidence interval 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%).

Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

**Incidence Greater Than 1% - Causal Relationship Probable:** All derived from clinical trials:

**Body as a Whole:** Abdominal pain or cramps, headache, fluid retention, abdominal distention

**Digestive:** Diarrhea, indigestion, nausea, constipation, flatulence, liver test abnormalities, \*PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

**Nervous System:** Dizziness

**Skin and Appendages:** Rash, pruritus

**Special Senses:** Tinnitus

**Incidence: 3% to 5% - Incidence of unmarked reactions is 1% to 2%.**

**Incidence Less Than 1% - Causal Relationship Probable:** The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.

**Body as a Whole:** Malaise, swelling of lips and tongue, photosensitivity, anaphylaxis, anaphylactoid reactions

**Cardiovascular:** Hypertension, congestive heart failure

**Digestive:** Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, hepatic necrosis, appetite change, gastroenteritis with or without concomitant hepatitis, colitis

**Hemic and Lymphatic:** Hemoglobin decrease, leukopenia, thrombocytopenia, hemolytic anemia, aplastic anemia, agranulocytosis, purpura, allergic purpura

**Metabolic and Nutritional Disorders:** Azotemia

**Nervous System:** Insomnia, drowsiness, depression, diplopia, anxiety, irritability, aseptic meningitis

**Respiratory:** Epistaxis, asthma, laryngeal edema

**Skin and Appendages:** Alopecia, urticaria, eczema, dermatitis, bullous eruption, erythema multiforme major, angioedema, Stevens-Johnson syndrome

**Special Senses:** Blurred vision, taste disorder, reversible hearing loss, scotoma

**Urogenital:** Nephrotic syndrome, proteinuria, interstitial nephritis, papillary necrosis, acute renal failure

**Incidence Less Than 1% - Causal Relationship Unknown:** Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.

**Body as a Whole:** Chest pain

**Cardiovascular:** Palpitations, flushing, tachycardia, premature ventricular contractions, myocardial infarction

**Digestive:** Esophageal lesions

**Hemic and Lymphatic:** Bruising

**Metabolic and Nutritional Disorders:** Hypoglycemia, weight loss

**Nervous System:** Paresthesia, memory disturbance, nightmares, tremor, tic, abnormal coordination, convulsions, disorientation, psychotic reaction

**Respiratory:** Dyspnea, hyperventilation, edema of pharynx

**Skin and Appendages:** Excess perspiration, exfoliative dermatitis

**Special Senses:** Vitreous floaters, night blindness, amblyopia

**Urogenital:** Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding

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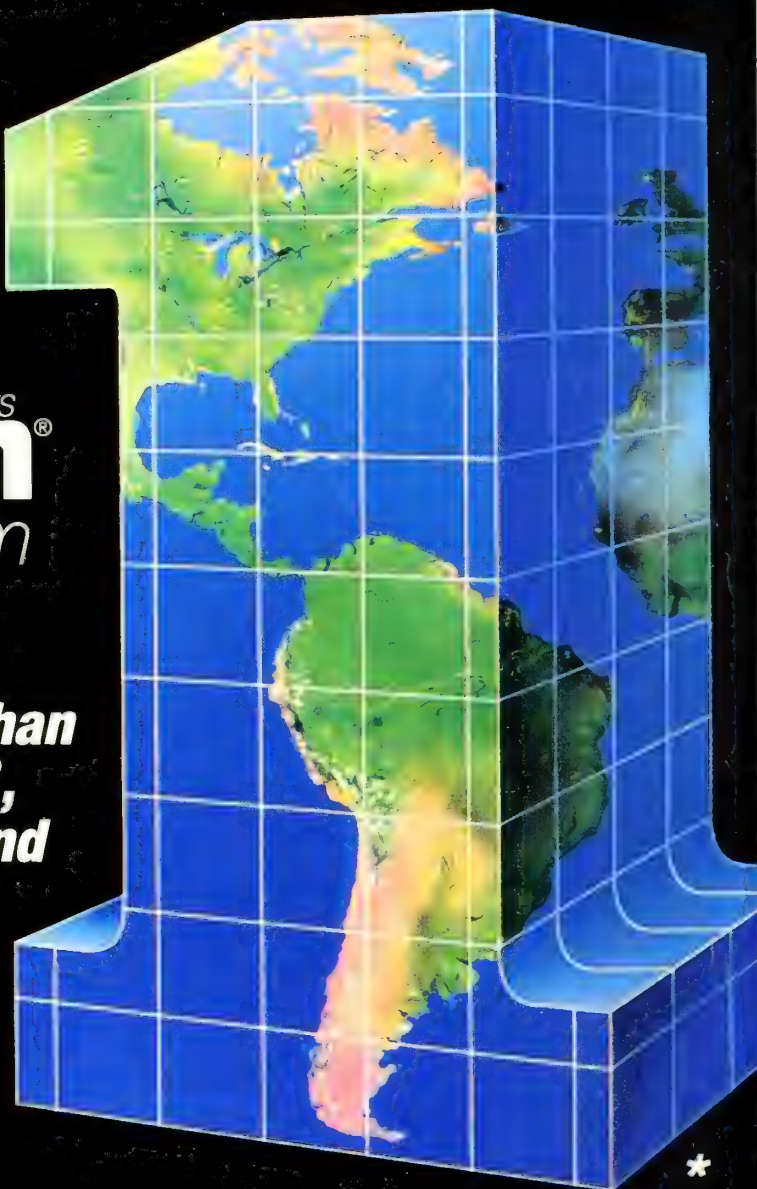


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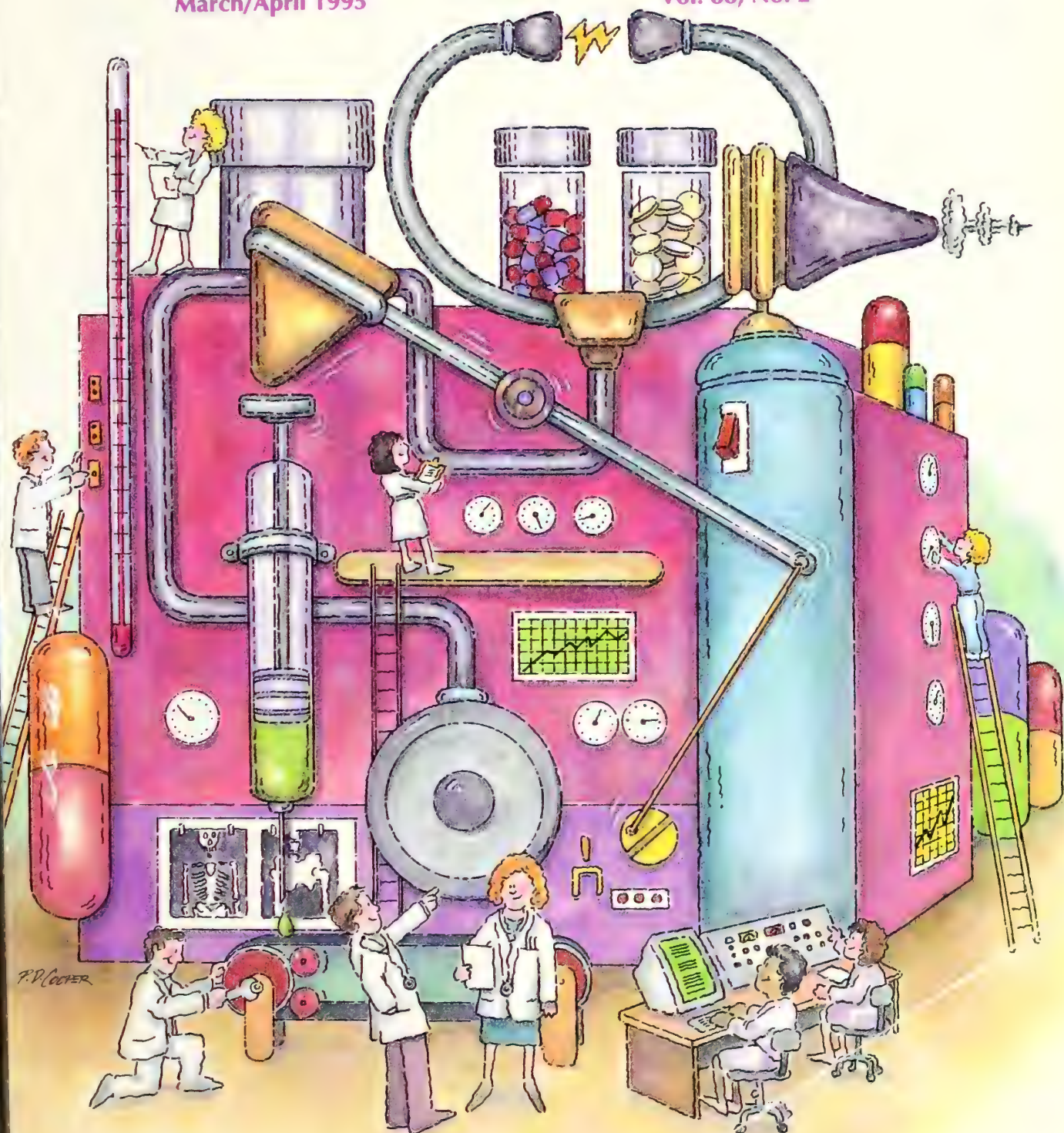


# INDIANA MEDICINE

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March/April 1995

Vol. 88, No. 2



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The Journal of the Indiana State Medical Association

March/April 1995

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Vol. 88, No. 2

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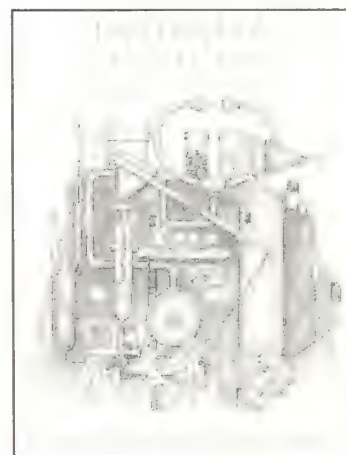
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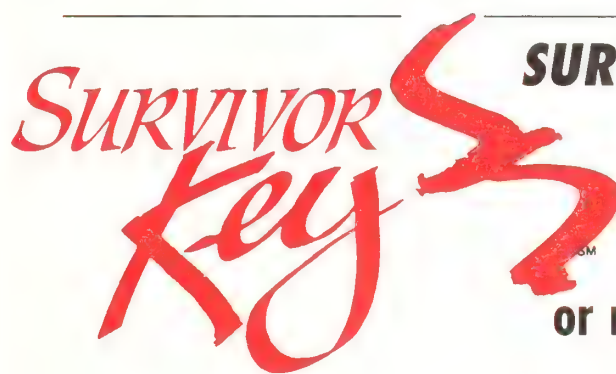
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### **ISMA past president to discuss INCAP on cable show**

Michael Mellinger, M.D., ISMA past president and AMA delegate, will be interviewed on "American Justice," an hour-long show on the Arts and Entertainment Network. Dr. Mellinger will discuss the Indiana Compensation Act for Patients (INCAP) on the show, which is looking at the malpractice issue from all sides – the medical profession, the trial lawyers and the patient – in a documentary format. The show is expected to air in April, but an exact date has not been announced. "American Justice" is broadcast at 9 p.m. Eastern time on Wednesdays.

### **Women physicians needed for Girl Scout mentoring program**

Girl Scouts throughout Indiana will get a rare look at life as a physician thanks to the Physicians of Tomorrow Mentoring Program sponsored by the ISMA and Girl Scout Councils throughout the state. The program provides young women with an inside look at careers in medicine.

Women physician volunteers are needed for the program, which teams up participating Girl Scouts with a woman physician in order to explore the scouts' interest in medicine. Physicians interested in becoming mentors should call Tim Brent at the ISMA, (317) 261-2060 or 1-800-257-4762.

### **ISMA to offer spokesperson training session**

The ISMA is offering a one-day spokesperson training for members April 26 at ISMA headquarters in Indianapolis. Pat Clark, a speech and communication trainer from the AMA, will conduct the training.

Participants will learn how to:

- enhance their ability to communicate to live audiences;
- master the art of leaving the audience with the message they want to communicate; and
- develop skills that will help them achieve a higher on-camera or on-stage comfort level.

Attendance is limited to 12 participants. To register or obtain more information, call Adele Lash at the ISMA, (317) 261-2060 or 1-800-257-4762.

### **ISMA and AMA dues not fully deductible**

Because of the Omnibus Budget Reconciliation Act of 1993, dues paid to associations with lobbying activities are no longer fully deductible as a business expense. The portion of ISMA dues allocated to lobbying expenditures for 1995 is 17%. This nondeductible amount is printed on the back of the ISMA membership card. For 1995, the nondeductible portion of AMA dues will be 33%.

Physicians should contact their county and specialty societies to determine the nondeductible portions of their dues, which vary by society. □

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## ■ letter to editor

### Third party has no role in patient-physician relationship

Rather than being out of step with the world, I feel like I am marching to a different drummer than the one described in the article on page 462 of the November/December issue of *Indiana Medicine* ("The new frontier for physicians: Revenue-focused"). I am sure that not everyone will agree with me; but on the other hand, I know some will.

To put this in context, I just retired from 40 years of family practice, logged over 2,200 deliveries and did my share with the Indiana Academy of Family Physicians, the ISMA and the AMA. I went into medicine to do what I could for the sick, the injured, the frightened and the lost. Had I expected the maximum income, I made some major mistakes on the first day out: 1. I chose to do family practice. 2. I chose to do it solo. 3. I chose to do it in a rural area. 4. I did not expect to ever move again.

I did expect a decent income. Had I decided to maximize my income, I was wrong on every count. I expected to fulfill my contract with each patient – give him my best. If he paid me, fine. If he did not, that was his problem. He was showing bad manners toward me. This contract implied that I recognize what was possible, then do it for the patient's benefit

first, not mine. The focus from day one was serving the patient while being aware of the cost to him – in dollars, in pain, in suffering, in lost work as well as the cost of drugs prescribed. That meant pointing out to him the costs of useless procedures and injudicious living.

Unfortunately, as I survey the field today, all I see and hear is how to generate "income streams." This appears to me to be a euphemism for how the physician can make money for a managed care operation and then he receives what is left after the stockholders are paid, but stockholders come first.

It appears that instead of the patient-physician relationship being the beginning of care, it is the end result after being filtered

through umpteen job holders. I know of no medical reason why a third party has a role in my contract with the patient. There were always enough sick, hurt, worried or fearful people out there that I did not need to worry about "securing patient lives and increasing market coverage."

It is stated on page 462 that the process of managed care is more "straightforward" than fee-for-service is (or was.) It appears that that straightforwardness is to involve a third party who has dreamed up a health plan that sees to it that the third party gets his part first – either money or a sense of power – and the physician gets what is left. I can see no sense of triumph nor completeness in a managed health plan except that it pays dividends to a stockholder.

On page 463, the author derides good service and patient referrals. I submit that the only worthwhile referral is from a satisfied patient. Who wants to spend a medical career seeing patients who do not want this service but are forced by a third party to use it? I believe that the medical contract is best served by a patient who seeks the contract rather than being sent to a physician not of his choice! □

E.M. Gillum, M.D.  
Portland

#### Letters to the editor

*I*ndiana Medicine welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., *Indiana Medicine*, 322 Canal Walk, Indianapolis, IN 46202-3268. □



## ISMA Members And Their Employees:

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<b>500</b>	■ \$500 calendar year deductible, \$1,000 per family ■ Stop-Loss limit \$5,000 per person, \$10,000 per family	✓	✓		
<b>1,000</b>	■ \$1,000 calendar year deductible, \$2,000 per family ■ Stop-Loss limit \$5,000 per person, \$10,000 per family	✓	✓		
<b>2,000</b>	■ \$2,000 calendar year deductible, \$6,000 per family ■ Stop-Loss limit \$10,000 per person, \$30,000 per family	✓	✓		
<b>250PPN</b>	■ \$250 calendar year deductible, \$500 per family ■ Stop-Loss limit \$5,000 per person, \$10,000 per family	✓	✓	✓	✓
<b>500PPN</b>	■ \$250 calendar year deductible, \$500 per family ■ Stop-Loss limit \$5,000 per person, \$10,000 per family	✓	✓		✓

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**North West Indiana** Ross MacLennan 219-769-6933 219-462-8066

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## ■ commentary

### Your good ideas can become resolutions at the AMA

Paula Hall, M.D.  
Mooreville

I once was interviewed and asked what advice I would give to new doctors about joining medical and specialty societies. I replied, "First and foremost, they should join their county society and the Indiana State Medical Association. As an individual, there is no doubt that you get 'the most bang for your buck' doing this." Then I advised them to join their specialty society so they could stay current in the ever changing world of medical information and technology. Next, I recommended that they join the American Medical Association.

The interviewer asked me what I would tell them to do if they did not have sufficient funds for dues to all these organizations. I immediately replied that I would not join the AMA. After, what has the AMA done for me?

I was pretty sure that the AMA was really just a group of "good ole boys" hobnobbing with the Washington bureaucrats, and I resented that they were doing this on my money and in my name.

Last October I was elected to fill a one-year term as an alternate delegate to the AMA. Last December I went to my first AMA meeting to "learn the ropes." Boy was I wrong about my earlier perceptions of the AMA!

The AMA, like the ISMA, is democracy as our forefathers imagined it. I saw no special interest groups and no lobbyists. Our delegation, led by Marvin

Priddy, M.D., and John MacDougall, M.D., represented the people who elected them. The delegates did not assume that because they were elected that they had inside information and could make better decisions than the mandates that the ISMA sent them to carry out.

I saw our delegates support resolutions that the ISMA had adopted, even though they personally did not agree with some of them. I know that they read reams of resolutions and reports because I read their synopses of these reports. I know that each position that the delegation took was well thought out and discussed because I was at the meetings. I watched our delegation go to the reference committees, gather more information, return to rediscuss the issues and again make informed non-prejudiced decisions. I never saw the delegation look at an issue from only a plastic surgeon's or a family practitioner's viewpoint. Instead, our delegation was a melting pot of all specialties, representing each of us in a non-selfish way.

The AMA really is not a "good ole boys club." The AMA is where an individual physician can not only be heard, but also listened to. An individual physician can in fact direct the policy of the AMA. It does not require "connections" or a large financial contribution. Instead, all that is required is a good idea.

If that good idea is presented to and accepted by the county medical society, then it is submitted to the ISMA as a resolution.

This resolution is assigned to a reference committee, which is an open forum for discussion. The individual physician who proposed this idea can attend the committee meeting and discuss the merits of the idea. However, even if the physician chooses not to do that, the county society will send a delegate who will speak on the resolution. After being discussed in the reference committee meeting, the resolution will be presented to the House of Delegates, where it will be discussed again. If your peers like your idea, they will vote in favor of it. If this resolution involves AMA policy, then the AMA delegation will take it to the AMA. Once at the AMA, the process of reference committees, discussions and voting begins again.

As you can see, all you have to do is present a good idea. The mechanism is in place to turn that good idea presented to your peers at the county medical society into policy at the AMA. At the AMA, an individual does have a voice at the national level. Now it is up to us at the grassroots level to propose some good ideas.

I want to thank our delegation of Bill Beeson, M.D.; Al Cox, M.D.; Dyke Egnatz, M.D.; Max Hoffman, M.D.; Shirley Khalouf, M.D.; John Knotte, M.D.; George Lukemeyer, M.D.; John MacDougall, M.D.; Barney Maynard, M.D.; Mike Mellinger, M.D.; Marvin Priddy, M.D.; and George Rawls, M.D., for representing us so well. I hope I am up to the task this year. □



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critical illness.*



# Shared 'vision'

Bob Carlson  
Indianapolis

For Ben Park, M.D., president and chief operating officer of American Health Network, it all comes down to who's going to manage the emerging health care delivery system. He believes it should be physicians.

American Health Network physicians not only manage the organization, they own it. An equity practice model like American Health Network also offers physicians the potential to benefit financially.

Physicians' interest in the changing health care environment in Indiana prompted *Indiana Medicine* to examine one of the many entities that is buying physician practices.

In this interview, Dr. Park explains how American Health Network works and how existing medical practices are being integrated into the growing network. He tells you how American Health Network got started, its long-term goals and its relationship with The Associated Group. And if you think managed care is a bad dream, Dr. Park has some opinions that may wake you up to the possible opportunities that managed care can bring.

For three half-days a week, Dr. Park sees patients at Lifework, the family practice he shares with five partners in Lebanon, Ind. The balance of his work week is dedicated to American Health Network, headquartered in downtown Indianapolis.

Dr. Park is a 1977 graduate of the Indiana University School of Medicine. While establishing his family practice, he completed graduate-level computer science courses at Purdue University. He founded Advanced Medical

Information Systems in 1984 and sold the company to Allmed Financial Corp. of Indianapolis in 1994. One of his current priorities is designing and implementing the electronic data systems for American Health Network.

## **Indiana Medicine: How was American Health Network created?**

**Park:** Some doctors from around Indianapolis would meet informally to have dinner and discuss the way that our practices were running. About two years ago we said, let's go ahead and make something happen. So we started in earnest. As the vision became more clear as to what we wanted to do as far as building a delivery system, it became obvious that we didn't have either the capital or the expertise in certain areas to carry this off.

So we started looking around for people to help us with our capital needs. We talked to several people who had the money, but The Associated Group really was the only one that seemed to understand what we wanted to do and shared the vision of what we wanted to create. It was also able to offer us expertise in areas such as actuarial and legal and licensure requirements and other things that we knew we would run up against. American Health Network was actually the product of a group of physicians. We went to The Associated Group to get help in making it a reality.

## **Indiana Medicine: What was the vision that you and your colleagues had in mind?**

**Park:** We started with where we



# results in new network

wanted the health care system to be, long term, and then we looked at what role we could play in that system. Our original vision was to provide high-quality, low-cost care to the greatest number of people that we could and to keep patients from having to change doctors when their insurance changed.

Then we traveled to California and other places where the health care delivery system is more integrated. What we found there was a group practice model that was taking risk on from insurance companies. It was usually a group practice with a primary care focus but also had a specialist component to it. Typically, the group would contact an insurance carrier and say something like, you hassle us by making us call you for authorizations, but you never turn us down, so why don't you just forget all that, give us the money that you would have spent on claims and let us manage it. We think that we can do a better job of that internally than you can trying to manage it externally with all these onerous rules and regulations that really don't work anyway. That was the model we looked at. It seemed to be very successful.

More importantly, the physicians who were practicing in those groups were very satisfied with their quality of life and with their practice. They were telling us that they would never go back to fee-for-service medicine, that managing the delivery system and being able to make fundamental changes in the way care is delivered to their patients was very rewarding.

**Indiana Medicine: So the network is a risk-bearing entity?**

**Park:** Yes. The network is fundamentally a group practice, a large group practice. We're an all-payer system, so we deal with all kinds of different payment schemes. But our desire is to move toward global capitation, so that we eliminate a large part of the hassle factor. Primary care physicians have been particularly affected by that over the last several years because the burden of managed care really falls on the primary care physician to get everything authorized, and reimbursement just hasn't kept pace with that. Actually, real income, adjusted for

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*Our original vision was to provide high-quality, low-cost care to the greatest number of people that we could and to keep patients from having to change doctors when their insurance changed.*  
”

inflation, over the last 10 years for primary care physicians is down, which is unusual. Most other specialties are up considerably.

**Indiana Medicine: With the demand for primary care physicians by managed care organizations, do you see the decline in income turning around for primary care physicians?**

**Park:** We believe the market is going to adjust and that it's going

to happen fairly quickly. If you look at Indianapolis, for example, we had a research firm do a study of that, and there's actually an excess of primary care physicians in Indianapolis. If we were in a managed care environment, there would be more primary care physicians here than you needed. I don't know what other cities are like, but if you look at the way managed care organizations employ demand management systems and mid-level providers, the combination substantially reduces the need for primary care physicians.

**Indiana Medicine: What geographic area does the network intend to serve?**

**Park:** Our initial target areas will be Indiana, Ohio, Kentucky and West Virginia. But it's really national in scope, perhaps in the fairly near term. We're currently working on some arrangements that are out of state. Because of the way it's organized, it's not hard to make it national. An individual operating entity like Indianapolis is responsible for what happens in Indianapolis. There's not somebody [in another city] telling the Indianapolis folks how to manage it. Similarly for Lafayette, Kokomo and the other areas we're involved in, including Louisville, Lexington, Fort Wayne, South Bend, Evansville and Columbus, Ohio.

**Indiana Medicine: What are some of the network's other goals?**

**Park:** The fundamental goal of the network is to design a health care delivery system so that it works better for the people it serves, including our patients as well as



the employers who buy services, either through insurance carriers or directly. The plan is to take this entity public, with the physicians as joint owners with The Associated Group, and to use the public capital to further the expansion.

**Indiana Medicine: What about the network's organizational structure?**

**Park:** The fundamental operating unit that the rest of the organization supports is the care council, a group of five to 20 physicians who are paneled together in an organization. The care council may be just one group practice if it's large enough, or it may be several solo and small groups coming together. That care council makes the medical policy decisions for their patients, and where we have full risk contracts, they do their own prior authorization and utilization review. Those are no longer insurance company functions. Those functions are returned to the physicians.

**Indiana Medicine: Does a care council include specialty as well as primary care physicians?**

**Park:** It can. It's up to the primary care physicians how they structure their care council. In some cases it'll have specialists in it. In most cases, at least in Indianapolis, it probably won't. But in other areas, it might be a total multi-specialty group. It's really up to the organizing physicians as to how they want to structure it. In Indianapolis, it's primary care-dominated, although there are discussions with some specialists going on now, and we expect to have some of those concluded in the near term. The

only requirement is that it be a physician-managed and directed organization.

In Indianapolis, for example, we have more than 100 partners, and we probably have 10 to 12 care councils. The care council is really where all the action happens, and the rest of the organization is there to support it. Most of the network organization exists to serve the care councils in their role of managing care. We provide information system support, and we'll have automated medical records, scheduling systems, tools that'll be used by the care councils to more effectively deliver care.

**Indiana Medicine: How does a physician join a care council?**

**Park:** We have a rigorous credentialing process all our physicians must pass. In addition, you can't join the network if you can't find a care council to accept you. You must have a care council invite you to be part of the organization.

**Indiana Medicine: Who in the network organization arranges for relationships with hospitals, labs, that sort of thing?**

**Park:** Once again, that occurs at the care council level. The care council decides what hospitals they want to use, what specialists they want to use, what kinds of services they want to use. We have actuaries and attorneys who help them negotiate the arrangements. Some hospitals are becoming very aggressive. In order to get a block of patients, they'll provide increased services in terms of discharge planning and even a nurse to go on rounds and expe-

dite the in-patient process.

**Indiana Medicine: Of the various delivery system models that are out there these days, which one is your network closest to?**

**Park:** We're a physician-driven and physician-owned equity model. If you look at what's going on in health care now, a lot of it is about control, who's going to end up with control of the health care delivery system. Some of the insurance companies still believe that they can position themselves to control the system. The Associated Group believes that physicians are the ones who should manage care. If you look around the state, you'll see hospital-driven strategies to control the delivery system and to keep the savings from decreased hospital utilization within the hospital system. We think that the savings from improving the delivery system should flow through to the actual managers, the people who are able to effect those changes. In our mind, that's the physicians.

**Indiana Medicine: Who manages the organization overall?**

**Park:** Fifty percent of the board and at least 50% of every committee within the organization is physicians. The medical policy council, which determines the medical policy issues, is all physicians.

**Indiana Medicine: Who's the other 50%?**

**Park:** Appointees from The Associated Group. Most of the committees are all physicians. The board is 50% physicians and 50%



The Associated Group representatives. Ben Lytle, president and chief executive officer of The Associated Group, is chairman of the board.

**Indiana Medicine: What share of the profits will The Associated Group receive?**

**Park:** Fifty percent.

**Indiana Medicine: Have you been successful in overcoming any physician animosity toward insurance companies?**

**Park:** We picked an insurance company as a partner because we thought its incentives were probably more closely aligned to ours than other folks'. Insurance companies are our customers. We're going to have to go to Prudential and Aetna and Anthem and provide them good quality service at a reasonable price, so it doesn't make any sense to have animosity toward your customers.

**Indiana Medicine: Do you think there may be a perception that this arrangement involving an insurance company and physicians is somehow a conflict of interest?**

**Park:** The Associated Group is primarily an investor in American Health and is getting us such things as tools that we need and actuarial skills. Our goal is to manage health care costs and improve quality. I don't think they have a conflict with that. The only conflict really exists when you start dealing with other insurance carriers because their concern is that we'll give unfair advantage to The Associated Group family of

companies. So we've really bent over backwards to make sure that doesn't happen, that all the other payers are treated fairly.

**Indiana Medicine: What are your current payer relationships?**

**Park:** We have contracts, soon to be signed, with Heritage, with Maxicare, Prudential. Our physicians are in the Prudential network. We've not lost any payers. We've been able to convince them that we're going to be fair about

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*Maybe I'm being naive, but I would not worry about sending any of my family members to the physicians in this network.*

”

the way that we deal with them.

Actually, under this scenario, insurance companies will have less control over things like benefits and eligibility for services because the physicians really will be making those determinations. For example, if we had someone in one of our full-risk global capitated contracts who did not have a particular benefit and we felt that providing that particular service would be the best thing for the patient, and ultimately for the cost structure as well, then we could pay for it.

**Indiana Medicine: What if the best interest of the patient and**

**the cost structure were not aligned?**

**Park:** They aren't in some cases. Currently, there's an incentive to overutilize services, which is clearly not in the best interests of the patients, and some physicians do indeed overutilize services to the detriment of their patients. We feel like that's a relatively small percentage of physicians, and the same 1% to 2% of the doctors who are overutilizing services now because of an economic incentive will be the same 1% or 2% who underutilize services when there's an economic incentive to do that.

The majority of physicians, we believe, given the right information, will make the right decision for their patient. Maybe I'm being naive, but I would not worry about sending any of my family members to the physicians in this network. I would not be concerned about the decisions they would make, regardless of the incentive systems they were operating under.

That's been one of the fundamental things that we keep coming back to as we look at the physicians that we'd like to have in this organization. One of the questions that frequently comes up is, would you send your family to this physician? We ask each other that as we're thinking about who we'd like to have in it. And if you can't answer yes, then you don't want them.

**Indiana Medicine: What are the criteria for admitting a physician to the network?**

**Park:** It's a merger, really, of our practices into the larger group practice. It's a number of things.

Can you work with this person? What kind of medicine do they practice? And once they've been invited to join a care council, that's a pretty strong endorsement. We do the standard credentialing things that you might expect in any kind of organization. We intend to be certified by the National Committee for Quality Assurance so we're going through that whole process.

**Indiana Medicine:** But what determines whether a certain practice or group is invited to join? How do you make that connection?

**Park:** It's a lot of things, and some of them are fairly hard things like the credentialing, and some of them are softer. We like physicians who have an involvement in education, for example, who spend some of their time teaching medical students or residents or nurse practitioners. We want physicians who are active in their communities, who have a good reputation.

**Indiana Medicine:** How fast is the network growing?

**Park:** We started about nine months ago with no physicians, and we have 110 now. We expect that we'll add an additional 300 physicians over the next year.

**Indiana Medicine:** Can you talk about dollars and cents?

**Park:** The average primary care physician in practice probably grosses about \$300,000 a year. The physicians' salaries are based on production just like they have been historically. It's not a salary system

per se like you might find in a staff model HMO where you see your patients and go home at five o'clock every day. Incentives to work hard are still there. The ability to vary your income by your work effort is still there as it has been in private practice. We tried to take the best things from private practice and leave those in place and then get rid of the things that most of us didn't like, particularly dealing with insurance companies. We try to centralize

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*Our fundamental belief was that for this organization to be successful, it has to do a good job of serving the primary care physicians and making it an attractive place for them to want to work.*  
”

that process, try to provide better record-keeping systems, more efficient administration.

**Indiana Medicine:** What is the financial risk to physicians in selling their practice to the network?

**Park:** There really isn't any. Essentially the physicians join, and three years from now, if they decide this is not what they like, then the transaction unwinds itself. There is an easy out for the physicians. At the end of three years, a physician may leave with no

financial penalty. The physician can buy back the practice assets at book value and resume practice. There's also not any of this onerous kind of non-compete clause that you find in most of these systems.

Our fundamental belief was that for this organization to be successful, it has to do a good job of serving the primary care physicians and making it an attractive place for them to want to work. If it doesn't do that, then they ought to leave. They vote with their feet.

**Indiana Medicine:** Would you recap how a physician would benefit from merging his or her practice with a network such as yours?

**Park:** The opportunity for improved lifestyle is one of the primary benefits. Some of our primary care physicians don't want to make hospital rounds any more, so now they have a designated person who does all the hospital rounds for their patients. Ultimately, it'll result in better quality of care for the patients, and it's also a little better lifestyle. Many of us now have only two or three patients in the hospital, and it doesn't make much sense for us to make rounds on those two or three people when, if we pooled all of our patients, we could have 20 patients and a full-time person there taking care of them.

As far as payer contracting, thus far, our payer contracts have improved anywhere from 15% to 50% over what the physicians were able to get on their own because we have a group negotiating with them. And as we grow the organization and take more of the insurance company kind of

functions out of the offices, people won't have to do all this prior authorization and utilization review with the insurance companies. It's something that the network will take care of for them.

A better place to work – less hassle day in, day out. American Health Network will take care of all the CLIA (Clinical Laboratory Improvement Amendments) regulations and the OSHA (Occupational Safety and Health Administration) regulations. In our practice, we spend an enormous amount of money just complying with OSHA. It's a lot easier in a large organization to just have a dedicated person handle this type of work.

American Health Network also believes in organized medicine, and we think the Indiana State Medical Association and the AMA have a very important role to play. They've been out there for us for all these years, and American Health Network encourages its physicians to join these organizations. If that's something our physicians want to do, then it's an expense the network takes on.

**Indiana Medicine: What changes have your patients noticed since your practice has become part of the network?**

**Park:** None.

**Indiana Medicine: How about your employees?**

**Park:** Better benefits. You know, it's odd. In some ways, as we joined this organization, our greatest fear was that there would be too many changes, and now that we're in it and it's working, our greatest frustration is that there haven't been more changes, for example, rolling out the computer system to do practice-wide automation of medical records. Or putting demand-management systems in so that we can deal with a lot of the telephone traffic at the office and have that provided on a more consistent basis at a centralized site. I wish we were further down the road with full-risk contracts, and we could get away from more of the insurance company hassle. It's going to take two or three years, though, for that all to happen.

**Indiana Medicine: If you could leave Indiana physicians with some thoughts about the practice of medicine and the network, what would they be?**

**Park:** Now more than any time in history, physicians have an opportunity to manage the deliv-

ery system and re-engineer it in their own vision of what they think is best for their patients. No one knows better than the physicians working with their patients how health care should be delivered in the United States.

Indiana physicians who haven't taken the time to understand what managed care is all about in its finest sense are going to really be threatened by some of the stuff we're doing. They think managed care is something that's going to go away some day if you just ignore it. And it isn't. It's coming because that's what the people who are paying the bill want. They want somebody actually managing the delivery system instead of having sort of a free fall as it is now. It's just a matter of choosing whether you're going to be swept along in the current or whether you're going to paddle and make your boat go the way you want it to. We've got our oars in the water. □

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# How to keep your practice running smoothly

**Bob Carlson**  
Indianapolis

**T**he relentless barrage of change in health care affects not only you, the physician, but also the support people in your practice. In theory, those people are there so you can concentrate on practicing medicine. In practice, everyone in your practice, including you, is part of a team. As the senior team member, you can have an enormous impact on the way your team performs.

To find out how physicians can influence the performance of their practice, and enhance its chances for survival in an increasingly competitive health care marketplace, we asked practice administrators from around Indiana how physicians can help their practices function better, how physician behaviors can create problems in a practice and how physicians should view the role of management in their practice.

The responses were surprisingly frank. There was the perennial complaint that some physicians don't document things in patient charts like they should. That some physicians can be demeaning in their relations with support staff. That some physicians inadvertently strangle their own practice cash flow and drive up administrative costs with their autocratic behavior.

More often, however, this informal *Indiana Medicine* survey revealed shining examples of physicians, support staff and administrators working in highly effective teams to prepare for

managed care, to meet increased competition and rising consumer expectations and to survive the challenges of change.

## **Difficult choices, little time**

Should you sell your practice to the hospital? The fee schedule in this new HMO contract looks good, but what else are you agreeing to? Should you join some of your colleagues in a group practice without walls? Or, should you merge your practice with that new equity practice network that's being talked about?

Whether you're a solo practitioner or a group practice, your answers to questions like these can have profound, long-lasting consequences in today's volatile health care environment. What's more, you don't have much time to make up your mind. The pace of change right now is relentless. Let's face it, you need help. You need to know what's going on in health care. And you need good advice from someone you trust, like your practice administrator or a good consultant.

"These are very complex issues and you really need to involve your manager in the decision-making process," advises Gary Erskine, administrator of Arnett Clinic, a 110-physician multi-specialty practice in Lafayette. "I think it's important for the manager to work as part of a team with the physicians who are involved in the governance of the group."

Ideally, one physician member, together with the practice manager, should make it his business to keep the group up to

date by attending local, regional and national seminars. If you're a solo practitioner or in a smaller practice, Erskine concedes that staying abreast of developments in health care may be harder to do. You may want to retain one or more consultants, but that can get expensive. The more solid your own knowledge base about the issues, says Erskine, the better off you'll be.

The more effective your group's governance mechanism, the more quickly you will be able to respond when opportunity knocks, says Mary Sturm, chief financial officer of Premier Radiology Network in Indianapolis. And, you're more likely to cut a better deal.

"When you're going through these joint ventures and collaborations, which are happening a great deal in the Indianapolis area, the strength of the organization really comes from your ability to govern yourself, integrate yourself into another governance structure and preserve your financial stability in that new organization," asserts Sturm.

What does governance entail?

Governance involves issues such as how your group makes decisions – autocratically or democratically. Whether or not you have regular, productive meetings with agendas. Whether or not you are developing the skills of individuals in your group and are doing strategic planning. If decisions have been made by one physician and that physician is ready to retire, for example, the group may be at a loss if the other physicians haven't been allowed to

develop their governance and decision-making skills.

Sturm says the governing structure depends mostly on the size of the organization. A relatively small group of about 10 physicians will probably make decisions collectively. That process becomes unwieldy with groups bigger than 10 to 15. A larger group will probably organize itself into an executive board and committee structure.

#### **Planning for managed care**

According to Chief Executive Officer Rich Hively, an executive committee (often also referred to as an executive

board) and board

structure works

well for the 16

physicians in

Orthopedics

Northeast, Inc., of

Fort Wayne. "We

started strategic

planning about four years ago,"

says Hively. "This year we decided

to meet every other month, or at

least quarterly, so we can have a

better feel for what's working,

make faster adjustments and

position ourselves properly." The

group's strategic planning agenda

includes items such as trimming

costs, refining outcome studies,

costing out all surgical and office

procedures and selecting a new

information system.

Orthopedics Northeast's first

strategic planning meeting lasted

eight hours. That was too long,

Hively concedes. They have since

been pared down to four-hour

sessions, usually on a Saturday

morning. "Now physicians look

forward to them," says Hively.

"They've seen that it's helped us."

Human resource development,

planning and cost cutting are not the only business strategies being adopted in the new, competitive health care marketplace. After decades of being taken for granted, patients are demanding the same status they have in the rest of the economy. In the new scheme of things, the patient is the customer. At Nasser, Smith & Pinkerton Cardiology, for example, "the customer is king," says Pam Bloch, reimbursement and training manager.

#### **The new health care consumer**

"It's the way we market our practice," says Bloch. "Patients

relatively rare for a medical practice. She says it comes from the physicians.

"Part of what's made us a fairly successful practice is the physicians' philosophy that the patient is always right," explains Bloch. "When we hire somebody, our personnel manager Annabell Stumm will say 'the patient is king here, and if you don't agree with that philosophy or don't feel you can fill that role, whether you're a secretary, a medical assistant, a nurse or whatever, then this is not the place for you.'"

Bloch recalls that she recently asked a supervisor to call a patient

who had expressed some displeasure and offer to correct the problem. "I'm not saying that everybody that comes in here goes skipping out the door thinking God,

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### ***The cause and effect relationship between patient-oriented physicians and a prosperous practice is not hard to illustrate.***

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come here, they're sick, they're scared. They need to be treated as though we care what happens to them, and that goes all the way to the business office. The way your business office treats your patients also reflects on your practice. We only have this practice because the patient is here and is sick."

In practice, that means, for example, that the patient is seen on time and that all diagnostic testing is performed in-house immediately after the initial examination. Test results are interpreted for the patient by the physician, and a treatment plan is proposed, all in one visit. Nasser, Smith & Pinkerton Cardiology is headquartered in Indianapolis, with satellite clinics throughout the state.

Bloch admits this customer-oriented philosophy may still be

what a wonderful place," says Bloch, "but it is our intent to treat every patient that way."

The cause and effect relationship between patient-oriented physicians and a prosperous practice is not hard to illustrate. Some physicians, observes Sturm, interrupt their practice to do personal business with their attorneys and stockbrokers. If patients complain because they have to wait longer, this can create what Sturm calls a "crisis environment." Over time, says Sturm, this can result in staff turnover, which is expensive, and can lead to patient turnover, which is even more expensive.

According to Erskine, this type of physician behavior is now the exception rather than the rule. All businesses, including health care,



are becoming more customer-conscious. In the health care industry, he ascribes this trend to increasing competition. "We're doing a whole lot more in terms of staff training, not just in technical areas but also in terms of how to deal with the public," says Erskine.

For Dick Cota, administrator of Methodist Sports Medicine Center in Indianapolis, customer relations is half of what he calls the "total package." Patients may not be able to evaluate the clinical skills of the doctor very well, but in Cota's opinion, they can tell quickly whether they are being treated as a valued customer. If that is not communicated by a staff trained in customer relations, the physician may never have the opportunity to apply his or her clinical skills. The customer may simply decide to go elsewhere. Cota's goal is to make the patient feel that he or she is the most important part of the practice. The clinical services provided by the physician and a favorable outcome complete the "package."

"We always talk about customer relations, but you can't educate your people and give them enough training in that area," says Cota. "You just can't do too much."

In a business as intensely people-oriented as a medical practice, hiring, training and retaining good people is an especially formidable challenge. As a physician, what you say and do and how you say it and do it can make or break your staff morale, your patient census and ultimately your practice.

#### **Happy people work harder**

"Run it like a business," advises Bob Underwood, administrator of

the Hammond Clinic, a multi-specialty practice with 80 physicians in Munster. That means that physicians should allow their management teams to handle personnel issues such as rates of pay and disciplinary actions according to consistent guidelines. Underwood says offices should have written policies and employee handbooks that should be followed in all cases.

Alice Cannon, the clinic's director of support services, advises physicians to allow the staff members whose expertise is in coding and billing to perform those functions. The physicians' help is essential in providing all of the pertinent data for billing, but staff members should be responsible for staying informed about current legislation and guidelines and ensuring that the coding and billing are done appropriately.

"Physicians need to come to the administrator on all issues that come up in the office," insists Becky Weiler, practice administrator of Arlington Urology in Indianapolis. "Physicians sometimes tend to get an idea and tell employees 'do this, this and that,' which may totally disrupt three other jobs in the office. I need to see what the ramifications are and if it's even doable."

In some cases, physicians themselves can benefit from seminars and classes, according to Kathy Christ, office administrator with Dr. Kenneth Davis and Associates, a two-physician orthopaedic practice in Evansville. "If doctors are going to a seminar that includes break-out sessions on human resources, I try to get them to attend," says Christ. "A lot of physicians have a great bedside manner with their patients because

they see this is where the money's coming from, but their bedside manner with their employees leave a lot to be desired. I think they can be demeaning at times and not show a lot of respect to their employees. Physicians need to realize that the positive versus negative attitudes of their employees directly affect the practice."

"Try to look at your employees as people who really want to do a good job," suggests Weiler. "Come to your administrator, let them work it out, and you will have happier people. Happy people are productive people who are willing to give a little bit extra."

Regular meetings between physicians and staff are something she doesn't see enough of, says Sturm. She recommends that physicians and staff meet at least quarterly to coordinate operations in a non-crisis atmosphere. Meeting regularly with the administrator and staff not only contributes to an orderly business environment but can actually generate time- and money-saving ideas. "If you've hired good staff, they know more about reception work and insurance than you do," says Sturm. She points out, for example, that physicians could significantly reduce the time staff spends responding to patient telephone inquiries by giving patients appropriate educational materials before they leave the office.

In practices with formal quality improvement programs, productivity is evaluated more in terms of process than people. Individual performance still matters, but the goal is to look at work processes and determine what is most cost-effective for the whole organization.



### Continuous quality improvement

Erskine says Arnett Clinic's continuous quality improvement is a new way of looking at how the organization does business and makes decisions. It's a data-driven process that sometimes points to the physician as the team member who can most cost-efficiently accomplish tasks such as entering the diagnosis code on a patient chart at the time the patient is seen or providing the necessary demographic information when dictating. When it comes to physician chores such as dictation and turning in hospital fee tickets, continuous quality improvement means avoiding backlogs and doing it right the first time.

"Don't get me wrong," says Erskine, "there are some things that are most cost-efficient to have support personnel doing. But some things are best done by the doctor at the time he's providing the service. Yes, he's the boss. He can have them go look it up, but he's paying for it. Ultimately, that's going to cost him more out of his own pocket."

In some instances, the costs may be far higher.

"I think it's time for physicians to take coding seriously," cautions Hively. "As we get into the managed care realm, and people start reviewing our records, it's the old Medicare adage: If it wasn't reported, it wasn't done."

Between Medicare, Medicaid and managed care, unreported

charges can run into some real money. Debbie O'Neal, care council manager with Family Medical Center in Danville, says her chart review committee conducts random checks to make sure coding and documentation are complete.

Another way physicians can lose out on reimbursements is failing to get appropriate precertifications. "We belong to 17 different health care organizations, and every one has a different set of rules," says Jan Everton, administrator of Nephrology and Internal Medicine in Indianapolis. "Sometimes," she admits, "it falls to the office staff to try to get paid for a procedure."

### All in the same boat

"The physician is in a position now where he has to practice medicine. He can no longer do it all," says Bloch. "The days of being able to see patients, do your own billing and take care of the nursing staff are over. Doctors have to recognize that they have to have people who can take that part of their job away from them and who create an atmosphere of teamwork."

With more and more rules and regulations, the administrator's job has also become much more stressful, says Hively. "You have no idea how many fires an administrator is fighting at one time."

For both physician and administrator, help may be just around the corner. Literally.

"When you put the knowledge base from physicians and non-physicians together, we usually find that the decision-making process has a more solid base than only physicians or non-physicians making recommendations," notes Erskine.

At Methodist Sports Medicine Center, one of the physicians has been in the position of "physician administrator" for the last four years, attending seminars on managed care, budgeting and the business side of the practice. Together, notes Cota, he and his physician administrator colleague bring better recommendations to the executive board. Although a physician with the interest and aptitude for this role can be hard to find, admits Cota, "it didn't take very long for the other physicians to see the value. I suppose they also feel great relief that they don't have to attend all those meetings."

But practice management is not a one-size-fits-all proposition. Every practice is different. Your best chance of success is to hire good people and let them do their job. □

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# Reducing liability risk in managed care

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**M**anaged care offers physicians and other providers new opportunities to form their own health plans and delivery systems, but it still poses a threat to some. Many questions about managed care and these new systems remain unresolved. In particular, who will be liable if a treatment decision goes wrong? What responsibilities will physicians have if cost-containment goals conflict with optimal patient care? What liability will physicians face as they assume responsibilities previously handled by HMOs and insurance companies? And how can physicians protect themselves against these risks?

## Liability concerns

Few court decisions have involved physician liability under managed care, but this may change in the future. Managed care is growing rapidly across the country. Physicians may increasingly be named as defendants when patients do not receive the care to which they feel entitled. In addition, two federal appellate courts have refused to hold managed care companies liable for malpractice when they work for self-insured plans, ruling that such state law claims are precluded under federal employee benefits laws. Additionally, without a utilization reviewer to blame, some patients may turn against physicians and hospitals for recovery. And, as medical groups take on the dual role of provider and payer, plaintiffs may find fertile ground to allege

conflicts between patient care duties, cost containment and economic incentives.

## Risk management

Physicians entering into a managed care contract or designing a new delivery system should keep in mind the potential for liability. Physicians should always consult with legal counsel and risk management experts ahead of time. Some suggested precautions include the following:

- Provide good medical care. Above all, physicians must continue to provide good medical care. If managed care offers an opportunity for financial gain, physicians must not allow economic factors to interfere with patient care. The 1993 decision in *Fox v. HealthNet of California*<sup>1</sup> points out the dangers of creating the appearance that financial decisions dictate patient care. In this case, HealthNet, a for-profit HMO, was sued for refusing to pay for an autologous bone marrow transplant for an enrollee who subsequently died from breast cancer. Although HealthNet's policy listed bone marrow transplants as covered services, treatment was denied on the grounds that the procedure was experimental when attempted at later stages of breast cancer. The estate, represented by the deceased enrollee's brother, showed that a HealthNet internal study had found that treatment prevailed at three of four other HMOs, and that in this case, the procedure was denied only

after an executive at HealthNet changed his recommendation. Perhaps most damaging, however, was the plaintiff's argument to the jury that the executive received bonuses based upon the denial of costly medical procedures. Although the case was later settled on appeal for an undisclosed amount, the jury ordered HealthNet to pay almost \$90 million in damages to the estate, including \$77 million in punitive damages. Although the patient's physician was not directly involved as a defendant, other cases have been filed against physicians and HMOs alleging that improper financial incentives led to negligent care.<sup>2</sup>

- Inform patients of medical recommendations. If, for example, a patient's plan will not pay for additional hospital days, and the physician believes early discharge creates a risk, the physician should fully explain that risk to the patient.
- Document recommendations and decisions. Physicians should objectively document in the patient's medical record the course of treatment recommended and the patient's decision. In doing so, physicians should be careful about how they express frustrations with the managed care plan. In one California case, the jury reportedly would have found the physician negligent (had he been a defendant) partly because the physician noted in the medical record that the patient had to

be discharged "because of pressure" from the utilization review company.<sup>3</sup>

- Challenge utilization reviewer decisions. Was the review decision made by qualified medical professionals? Was a denial for surgery or extended hospitalization reviewed by a licensed physician? Was a specialist involved? The most important case to date suggesting steps that physicians might take if treatment plans are denied is the mid 1980s

California decision of *Wickline v. State*.<sup>4</sup> In that case, MediCal, California's Medicaid program, refused to grant a request for

additional hospital days for Lois Wickline, who experienced complications following surgery to

treat circulatory problems in her legs. Her treating physician requested an eight-day extension to her scheduled discharge date. However, MediCal approved an extension of only four days. Wickline was discharged after the four-day extension but had to be readmitted nine days later. Eventually, her leg was amputated. She brought suit against MediCal, alleging that the payer had been negligent in failing to approve the full eight-day extension. The California court ultimately held that MediCal could not be held liable for negligence in this case because the actual decision was made by Wickline's physician, not the

payer. Although Wickline did not sue her physician, the court was greatly disturbed by the physician's conduct. The court noted that physicians have a responsibility to inform patients when they disagree with decisions regarding coverage.

- Help patients take advantage of their right to appeal. Medical groups may need to help their patients take advantage of any appeal rights. Self-insured plans, in particular, must have an appeals process that the patient can initiate by written request.
- Be certain the practice can

defamation, breach of contract and antitrust violations, which may be involved when providers do their own credentialing and utilization review.

- Handle credentialing carefully. Medical groups that handle their own credentialing should carefully analyze how physicians are credentialed. In several cases, hospitals and HMOs have been found responsible for negligently credentialing and selecting physicians. In addition, the Medical Society of the District of Columbia just filed a lawsuit against a preferred provider organization alleging

that the PPO falsely implied that doctors who were excluded lacked sufficient training and certification, did not meet community standards and did not

deliver cost-effective health care.<sup>5</sup>

- Avoid using terms like "highest quality." Physicians should be leery of ad campaigns that present them as the "highest-quality" providers. Medical groups that consider the phrase harmless enough to use in a managed care contract may have held themselves to a higher standard and find they have more difficulty settling a case or defending a decision before a jury.
- Choose the best organizational option. The type of legal organization and how the organization presents itself to patients may also affect liability. New legal entities such as limited liability

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### ***Medical groups that handle their own credentialing should carefully analyze how physicians are credentialed.***

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meet patients' needs. Medical groups that sign capitated contracts or serve as gatekeepers should be careful that the practice can adequately address the needs of all expected patients. Communication between primary care physicians and outside specialists is also important. Groups must be careful if they are responsible for determining which specialists to refer to and when a referral is appropriate, particularly if the decision has a financial impact on the practice.

- Maintain adequate malpractice insurance and be aware of policy exclusions. Policies typically do not cover non-medical claims, such as



corporations and limited liability partnerships may afford networks the ability to protect members from negligence committed by other members in the network.

- Design cost-containment incentives so they don't influence patient care. Managed care organizations that work with capitated or risk-bearing medical groups are being advised to reduce their risk by disclosing that the gatekeeper or capitated physician is financially at risk for health care decisions.<sup>6</sup> This strategy may focus attention on the primary care group and how it makes referral decisions. An appeal mechanism involving outside physicians may benefit groups that conduct their own utilization review activities.
- Have legal counsel review managed care contracts and new delivery arrangements.

Overly broad indemnification clauses appear in many managed care contracts. These clauses can obligate the medical group to reimburse the managed care organization or network for legal fees and court costs if a claim results from the medical group's actions.

### Conclusion

Unquestionably, while managed care presents new challenges and opportunities, physicians need to keep in mind that the law moves more slowly than market reforms. Legal principles that in the past have applied only to HMOs and hospitals may be used as new tools to allege liability in the future. Until the courts or Congress sort out the duties of the participants in these new systems, prevention will likely pay off later. □

*The author is a shareholder and officer of Fredrikson & Byron, P.A.,*

*and co-chair of its Health Law Practice Group.*

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## ■ drug names

### Look-alike and sound-alike drug names

**Category:** Antipsychotic agent  
**Brand name:** Loxitane, Lederle  
**Generic name:** Loxapine  
**Dosage forms:** Capsules, injection, concentrate

#### LOXITANE

**Category:** Antihypertensive agent  
**Brand name:** Loniten, Upjohn  
**Generic name:** Minoxidil  
**Dosage forms:** Tablets

#### LONITEN

**Category:** Antiviral agent  
**Brand name:** Flumadine, Forest  
**Generic name:** Rimantadine HCl  
**Dosage forms:** Tablets, syrup

#### FLUMADINE

**Category:** Hormone  
**Brand name:** Eulexin, Schering  
**Generic name:** Flutamide  
**Dosage forms:** Capsules

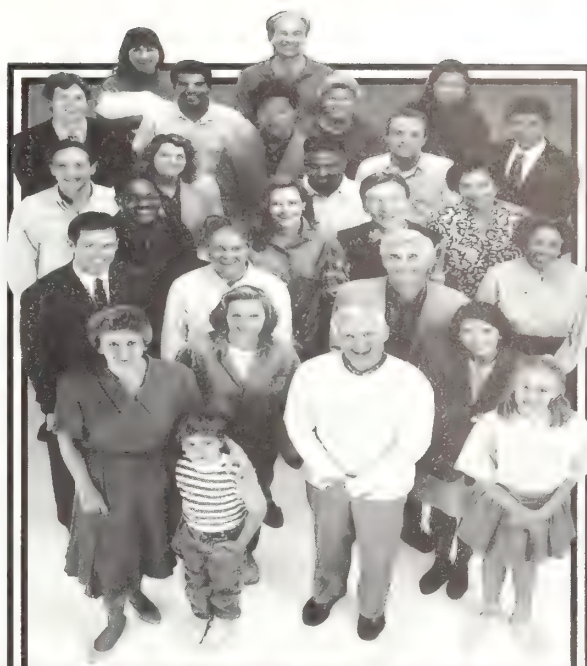
#### FLUTAMIDE

**Benjamin Teplitzky, R. Ph.**  
**Brooklyn, N.Y.**

**L**ook-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □

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*The Arthur G. James Cancer Hospital and Research Institute, Columbus, Ohio*

# THE JAMES

THE NEXT GENERATION OF HOPE

# Asset allocation: A proven strategic approach to investing

Joel M. Blau, CFP  
AMA Investment Advisors, L.P.

What does it really take to structure a successful investment portfolio? Various investment "experts" have different opinions. Some suggest that market timing is the best strategy, while others believe in individual security selection. However, studies have indicated that asset allocation – the way your funds are diversified across different classes of investment vehicles – has the greatest impact on your overall investment success.

Two separate studies by Brinson, Hood and Beebower of 91 large pension plan portfolios were conducted over two different 10-year periods. They found that 94% of the portfolio's total return was a function of asset allocation. Only 4% of total returns resulted from individual security selection, and just 2% was attributable to market

timing. So, while most investors spend 100% of their time focusing on market timing or security selection, the studies illustrate that asset allocation is the key to constructing a successful portfolio.

The asset allocation strategy is designed to maximize investment returns and minimize risk. Investments are spread among three broad asset classes, equities (stocks), fixed income (bonds) and cash (money markets). Over time, the classes generally react differently to changes in economic conditions and financial markets. By diversifying your investments among different classes, you can reduce your overall risk since losses from one class of assets can be offset by the gains in another class. Within the general classes, there are different subcategories. For example, equity class categories include U.S. large company stocks, U.S. small company stocks and international companies. Fixed income is categorized by length of

maturity and includes both U.S. and international bonds.

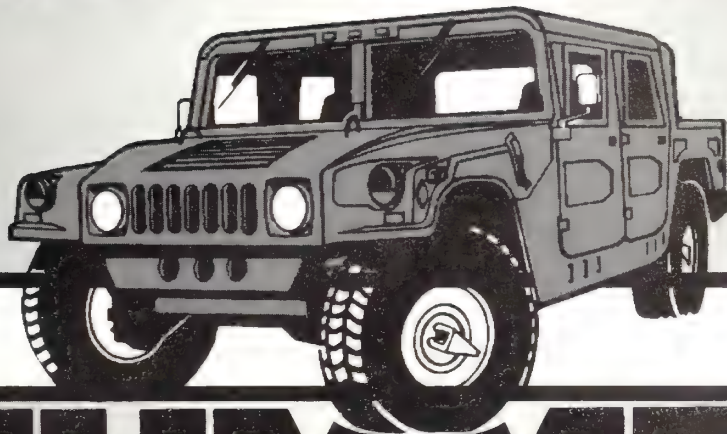
Your specific time horizon is an important factor in determining the allocation of your portfolio. The investment goal time frames may be long-term (retirement), medium-term (college education) or short-term (buying a new home). In general, investors who have longer time horizons can afford to include a larger percentage of equities in their portfolios. Stocks can be volatile over the short term, but they offer good appreciation potential over the long term.

To effectively construct a portfolio based on asset allocation, you must rely on historical data. The key is using the appropriate time frames and varying asset classes to determine historic correlations. □

*Mr. Blau welcomes readers' questions. He can be reached at 1-800-262-3863.*



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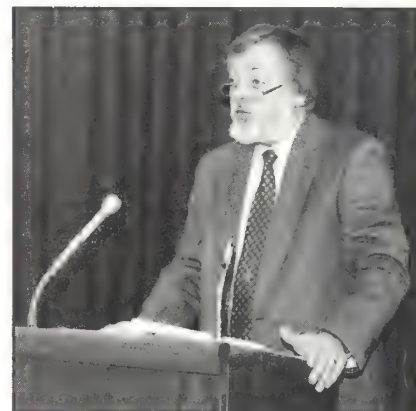
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# Health care issues discussed during Medicine Day



George Wolverton, M.D., left, a Clarksville family physician, and his wife, Betty, share a luncheon table with Rep. William Cochran, D-New Albany.



Michael Mellinger, M.D., a LaGrange family physician, speaks during a Medicine Day news conference at which the ISMA endorsed HB 1009, which deals with insurance reforms, and SB 422, the Patient Protection Act. Medicine Day, held Jan. 25, included a visit to the Statehouse so physicians could meet with their legislators and a luncheon for physicians and legislators.



Ralph Stewart, M.D., a Vincennes ophthalmologist, right, and his wife, Pat, talk with Rep. Richard McConnell, D-Princeton, at the luncheon at the Hyatt Regency.



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# Physicians, legislators attend 'Beach Party'



Sen. Patricia Miller, R-Indianapolis, talks with John McGoff, M.D., left, an Indianapolis emergency physician, and Barney Maynard, M.D., an Evansville urologist, at the ISMA/IMPAC legislative reception, which was held Jan. 25 and featured a Beach Party theme.



Dennis Lawton, M.D., a Muncie family physician, center, is pictured with Rep. James Vanleer, R-Muncie, left, and Rep. Gregory Porter, D-Indianapolis.



N. Stacy Lankford, M.D., center, an Elkhart urologist, and his wife, Zane, talk with Sen. Marvin Riegsecker, R-Goshen.



John Osborne, M.D., right, a Muncie surgeon, discusses legislative issues with Rep. Jeff Espich, R-Uniondale.

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# Approach to the patient with a soft tissue mass

Bruce T. Rougraff, M.D.  
Indianapolis

Soft tissue masses are extremely common in adults. Fortunately, the majority of these masses represent inflammatory or benign neoplastic lesions. Soft tissue sarcomas are relatively uncommon (1.4/100,000 people per year). Because an inappropriate initial management of the unusual soft tissue sarcoma can result in a compromised result, it is important for the clinician to have a rational approach to the patient with a soft tissue mass.

Unlike a patient with a bone tumor, which usually has a characteristic radiographic appearance, soft tissue tumors are much more difficult to diagnose before the biopsy. However, there are certain clinical clues to the diagnosis of a soft tissue mass.

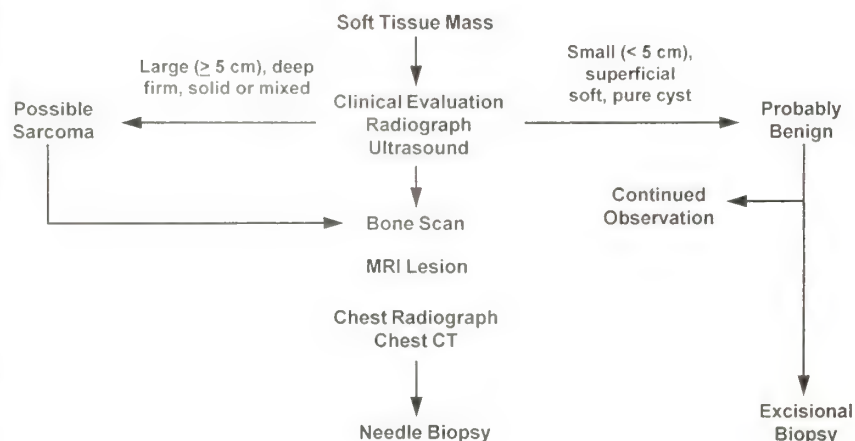
First, the size of the mass is critical. A mass that is small (less than 5 cm in its greatest dimension) is unlikely to be malignant, while a mass that is greater than 5 cm has at least a 20% chance of being a soft tissue sarcoma.<sup>1</sup> The size of the lesion can be determined by physical examination if the lesion is subcutaneous and

easily palpable, or by ultrasound, computed tomography (CT) or magnetic resonance imaging (MRI).

The second diagnostic clue for a soft tissue mass is whether the lesion is subcutaneous (superficial) or intramuscular (deep). Superficial lesions are more likely to be benign<sup>2</sup> and, when malignant, may have a better prognosis than deep lesions.<sup>3</sup> The depth of the lesion is best determined by physical exam, ultrasound or MRI. The thigh and buttocks are the two most common sites for soft tissue sarcomas. Any large deep mass in the thigh or buttocks should be considered at high risk for being a malignant lesion.

The third diagnostic clue for a soft tissue lesion is the consistency of the lesion on physical examination. Soft tissue sarcomas tend to be firm and not very painful until they get very large and compromise their vascular supply or adjacent neural structures. Lipomas are usually nontender and soft to palpation. A deep lipoma (intramuscular or infiltrating) may feel firm to palpation when the muscular compartment is flexed. However if that compartment is relaxed, the mass will then seem to "change" to the more classic soft consistency. Infectious and inflammatory lesions tend to be painful to palpation, may feel warm to the touch over the skin and cause a certain amount of apprehension to the patient. Another lesion that can be as-

## Diagnostic Strategy for a Patient with a Soft Tissue Mass





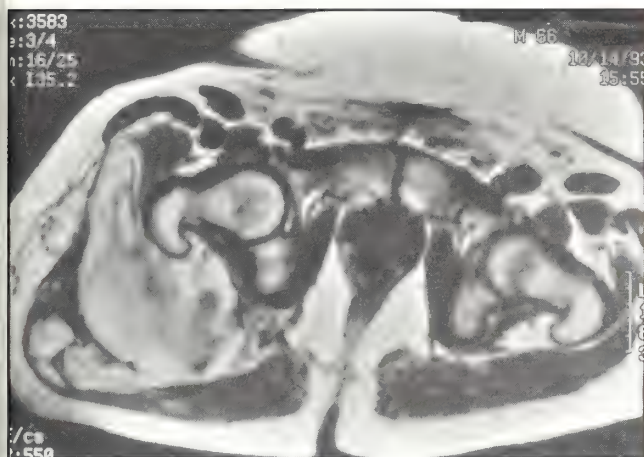


Figure 1A

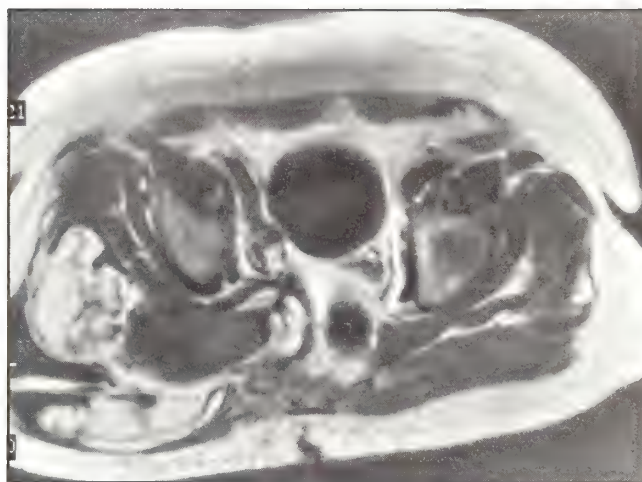


Figure 1B

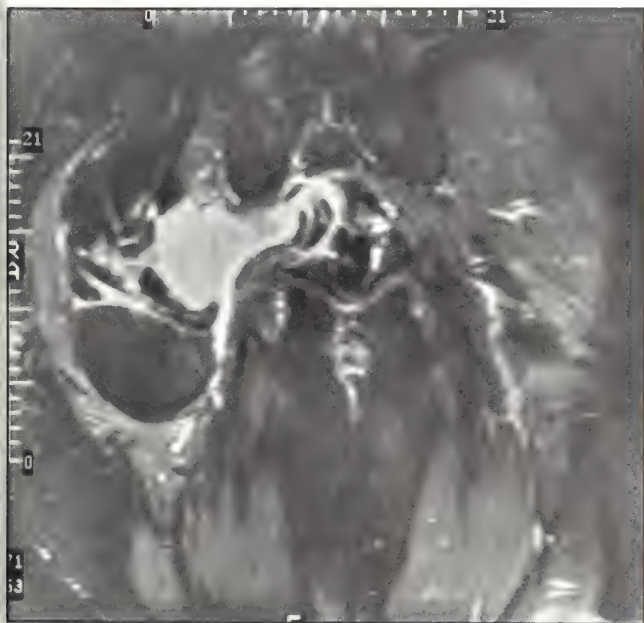


Figure 1C

Figures 1A, 1B and 1C: These are the MRI studies of a 66-year-old man with the history of a large buttocks mass for two years. In Figure 1A, the large mass with the same T1 signal as the subcutaneous fat (i.e., high T1 weighted signal) is consistent with a large intramuscular lipoma. On Figure 1B, on a more proximal cut (on the same T1 weighted study), there is an area of low signal intensity which is within the sciatic foramen and is displacing the rectum. On Figure 1C, a STIR sequence nicely delineates the abnormal area that appears to be growing into the pelvis. The mass was biopsied with a fine needle technique and interpreted as a benign lipoma. The entire mass was resected en bloc, and the final pathology was consistent with a high-grade, dedifferentiated liposarcoma.

essed on physical examination is a pseudoaneurysm. These are unusual lesions that can get very large, look like a sarcoma on imaging studies but on physical examination they should be pulsatile and have an audible bruit with auscultation.

The fourth diagnostic clue is

whether the lesion is cystic or solid. If the lesion is superficial and distal in the extremity, a light may be used to transilluminate the lesion. Otherwise the best test for this clue is an ultrasound. An MRI also can provide information about whether the lesion is solid or not. Most cystic lesions are inflamma-

tory or benign lesions, such as ganglion cysts or soft tissue abscesses. If the lesion is solid, it could represent either a benign or malignant neoplasm. Caution should be taken with the rare large, deep, cystic lesion that is not near a joint. A malignant fibrohistiocytoma occasionally can

present as a mostly cystic mass.

The fifth clue comes from the history of how long the patient has been aware of the mass. Clearly, a mass that has rapidly increased in size over two months is more likely to be a sarcoma than the lesion that has slowly enlarged over a 20-year period. A mass that increases and decreases in size is usually a cystic lesion. However, caution should be taken with masses that have been present for a long time. Soft tissue sarcomas occasionally present with a history of many years duration. The longest length of symptoms of a mass before diagnosis of a soft tissue sarcoma in the author's experience has been 30 years.

The sixth diagnostic clue comes from the radiographic studies. Every soft tissue mass that is going to undergo intervention should have a plain radiograph. Clues from the radiograph include a fat density lesion (lipoma), punctate calcifications (synovial cell sarcoma, soft tissue chondrosarcoma or hemangioma), ossification (soft tissue osteosarcoma or myositis ossificans), and skeletal abnormalities (osteomyelitis, primary bone lesion or periosteal reaction from the soft tissue tumor).

A CT is a good test to define cortical bone abnormalities and obtain information as to the extent of the mass. If done with soft tissue windows, it is an excellent test to diagnose lipomas. Although less expensive than an MRI study, it does not reveal the anatomy or the internal characteristics of the tumor as well.

The MRI gives the most information of any radiographic study but should be reserved for large lesions or those that are ill-defined. It will clearly delineate whether the lesion is a bone lesion

with a very large soft tissue component (bone malignancy) or whether the lesion is a primary soft tissue lesion. With different pulse sequences, the radiologist can identify one of three patterns. A lesion can have a low T1 weighted and a low T2 weighted sequence, which means that it is either an extra-abdominal desmoid tumor, extensive scar tissue, cortical or dense bone or a foreign material such as bone cement or air. A lesion can have a high T1 and a high T2 weighted sequence that means that it is most likely a lipoma. A low-grade liposarcoma occasionally can present with the same imaging characteristics (see *Figures 1A, 1B and 1C*). The third pattern is a low T1 and a high T2 sequence. This could be any lesion, neoplastic or otherwise, benign or malignant.

After evaluating the patient with physical examination and perhaps an ultrasound, the size of the lesion is known. If the lesion is small – less than 5 cm – and subcutaneous, it is unlikely to be malignant and should be observed. If the patient insists, an excisional biopsy with a small, longitudinal incision and good hemostasis is the next most appropriate step. As long as the biopsy tract and hematoma can be re-excised en bloc at a later surgery, the patient will not have a compromised result if the excisional biopsy is consistent with a sarcoma. If the lesion is greater than 5 cm in any one direction, an MRI is indicated before biopsy of the lesion. The quality of the imaging studies is impaired if carried out after an incisional biopsy, less so with a needle biopsy because of less trauma to the tissues. If the lesion is larger than 5 cm, it still is more likely to be benign than malignant.

The five most common benign

soft tissue masses that can frequently be large at the time of presentation are: lipoma, desmoid, intramuscular hemangioma, neurilemoma and neurofibroma. Of these five benign neoplasms, usually lipomas and desmoids, and sometimes hemangiomas, can be diagnosed from their imaging characteristics on MRI (see *Figures 2A and 2B*). Neurilemmomas usually are associated with slow growth by history and on physical examination have a positive Tinel's sign indicating nerve compression. Neurofibromas frequently occur in patients with neurofibromatosis. However, half of all neurosarcomas occur in patients with neurofibromatosis. Beware of a rapidly enlarging mass in an adult patient with neurofibromatosis because it may represent a neurosarcoma.

After evaluating a patient with a large soft tissue mass, greater than 5 cm, with a plain radiograph and an MRI, a needle biopsy is the next most appropriate diagnostic procedure. This can be done with a variety of techniques.

Cutting needles, such as a Tru-Cut needle, obtain a small piece of tissue that allows the pathologist to evaluate the architecture of the lesion as well as the nuclear morphology. Fine needle aspiration is a successful biopsy technique for an experienced pathologist; however, it offers no advantage in morbidity to the patient over a cutting needle biopsy and may be less accurate in determining the histologic subtype and grade.<sup>4</sup>

An incisional biopsy may be necessary in approximately 5% to 10% of patients because they have a nondiagnostic needle biopsy. Careful attention to the details of an open biopsy must be followed to allow a safe surgical resection,



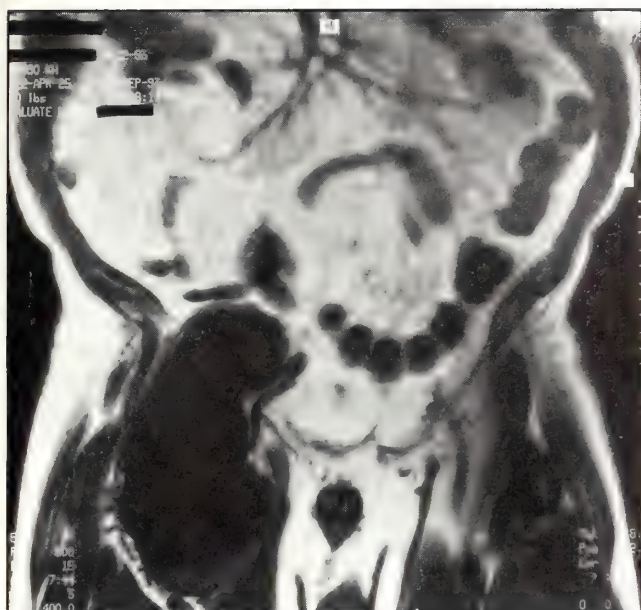


Figure 2A

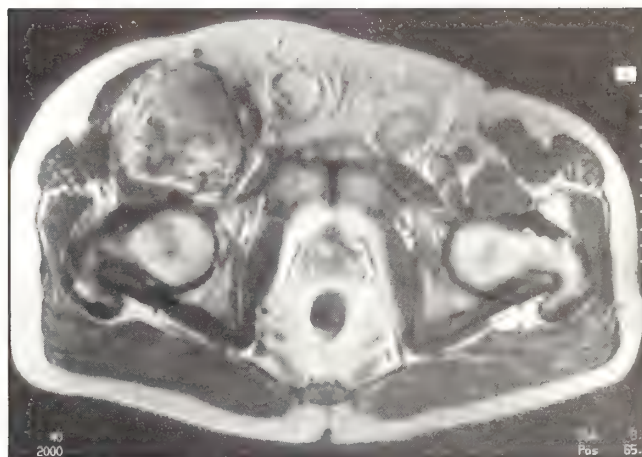


Figure 2B

Figures 2A and 2B: These are the MRI studies of 68-year-old man who had a proximal thigh mass for almost 30 years. The mass recently caused him increased pain and weakness. The mass is very large, extends inside the pelvis under the inguinal ligament and has a low-signal intensity on T1 weighted sequences (Figure 2A). On Figure 2B, the mass is higher intensity on the T2 weighted study. This is nondiagnostic on MRI but is worrisome for sarcoma. On physical examination, he had definite quadriceps weakness and a Tinel's sign over the femoral nerve. The mass was biopsied with a fine needle, which was non-diagnostic, and with an incisional biopsy, which was consistent with a benign process, uncertain histologic type. The mass was excised en bloc, and the final pathology was consistent with a large neurilemoma.

instead of amputation, if the lesion is a sarcoma.<sup>4</sup> Most cancer centers believe that the surgeon who biopsies a soft tissue sarcoma should also be the person responsible for the resection or amputation. Before performing an incisional biopsy, physicians should ask themselves whether they are adequately prepared to treat a patient with a soft tissue sarcoma or if the patient should be referred to a center with a multidisciplinary team that routinely treats these patients.<sup>5</sup> This may require the occasional referral of a patient with a large, nonspecific mass (based on the MRI character-

istics) that ultimately is diagnosed as a benign neoplasm.

In the unusual patient with a soft tissue sarcoma, several prognostic factors become important. First and by far the most important is the stage of the patient. Metastatic disease from soft tissue sarcomas is most frequently identified in the lungs, less frequently in the draining lymphatics and the skeleton. The standard staging studies include a physical examination of the lymph nodes, a chest radiograph, a chest CT, a whole body bone scan and possibly a gallium scan.<sup>6</sup> A patient with nonmetastatic disease at presenta-

tion has a far better prognosis than one with metastatic disease.

The second most important prognostic variable for patients with soft tissue sarcomas is the histologic grade. Patients with high-grade lesions have a worse prognosis than patients with low-grade lesions. Establishing the grade of a tumor requires an adequate tissue sample since sarcomas can have a heterogeneous cellular morphology. What can appear as a low-grade lesion on a limited sample may have high-grade areas after complete evaluation of the tumor at the time of surgical removal.



A third prognostic variable for soft tissue sarcomas is the size of the lesion. Although small lesions (less than 5 cm) are rarely malignant, when they are, they have a better prognosis than larger lesions. The size cut-off is somewhat arbitrary, but small is considered less than 5 cm to 8 cm in most studies.<sup>1,2</sup> This is measured as the single largest dimension of the mass.

The fourth prognostic variable is the depth of the lesion.<sup>3,7</sup> Superficial (subcutaneous) soft tissue sarcomas have a better prognosis than deep (below the muscle fascia) lesions.

The methods used for local control of soft tissue sarcomas include surgical resection or amputation, radiation therapy or a combination of both. Systemic control includes the use of intrave-

nous chemotherapy. The use of adjuvant chemotherapy for nonmetastatic soft tissue sarcomas is controversial because it has not been shown to be very effective in improving survival and is associated with a significant patient morbidity and cost.<sup>8</sup> □

*The author is assistant professor of orthopaedics and pathology at the Indiana University Medical Center.*

#### Correspondence and reprints:

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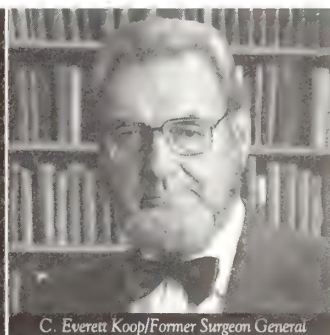
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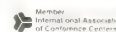
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# Indianapolis hospitals standardize changes in prothrombin time testing

Constance Danielson, M.D., Ph.D.  
Larry Howie, M.T.  
Kenneth Ryder, M.D., Ph.D.  
Indianapolis

Pathologists and technologists involved in coagulation testing in the major Indianapolis hospitals met Oct. 13, 1994, to discuss possible standardization of prothrombin time (PT) testing and reporting.

The PT test is a valuable screening procedure used to detect deficiencies in factors of the "extrinsic or common clotting pathways," including vitamin K dependent factors VII, X and prothrombin. Commonly used to monitor patients on oral anticoagulant therapy, the test is performed by adding thromboplastin to the patient's citrated plasma and measuring the time to form a fibrin clot. Unfortunately, the sensitivity of the test to a number of factors, including instrumentation, percent of citrate anticoagulant and the thromboplastin reagent used, can result in significant interlaboratory variability.<sup>1-3</sup>

Differences in the sensitivity of various thromboplastins to the effects of oral anticoagulants can be especially problematic and potentially result in suboptimal patient care. To minimize the effect of using different thromboplastins on the results of the PT test, the

World Health Organization has recommended use of the international normalized ratio (INR) when reporting the results of patients maintained on oral anticoagulants.<sup>4</sup> The INR is defined by this equation:

$$\left( \frac{\text{Patient's PT in seconds}}{\text{Mean normal PT in seconds}} \right)^{\text{ISI}} = \text{INR}$$

The INR is a mathematic adjustment of the PT time in seconds that corrects for the differences in sensitivity to warfarin of the various thromboplastins. The international sensitivity index (ISI) is a measurement of the thromboplastin's sensitivity to warfarin and is determined by comparing the thromboplastin being used to a standard reagent (the primary international reference preparation), which has been assigned an ISI of 1.0. The higher the ISI of any given thromboplastin, the less responsive or sensitive that thromboplastin is to the effects of warfarin. The mean normal PT in the above equation is determined by testing a minimum of 20 plasmas from normal people using the same instrument that will be used to test patients' PTs with that lot of thromboplastin. It must be determined by each laboratory each time a new lot of

thromboplastin is used.

To determine the amount of interhospital variability in PT testing and reporting, a questionnaire was sent before the conference to each of the 13 Indianapolis hospitals. A summary of the responses is shown in the *Table*. Most hospitals use medical laboratory automation (MLA) instruments. A variety of thromboplastin reagents are being used. Several laboratories currently use Thromboplastin, C (Baxter Diagnostics; DADE<sup>®</sup>), which will soon be phased out of production and necessitate a change. The reagent chosen for future use will have a different ISI (responsiveness to warfarin). Use of a new thromboplastin reagent will significantly change the PT results in seconds, especially in patients on oral anticoagulation therapy. This can lead to confusion and possibly underdosing or overdosing. Because the INR is corrected to account for the variation in responsiveness to warfarin of different thromboplastin reagents, the INR results of the PT test should be minimally changed. The survey responses indicate that, in Indianapolis, PT testing results are currently reported as INR as well as in seconds.

The conference began with lectures presented by Douglas Triplett, M.D., assistant dean, Indiana University Medical



Table

## Results of prothrombin time testing survey

Indiana Hospitals Surveyed: 13

Indiana Hospitals Responding: 13

Hospitals in which results of  
Prothrombin Time Testing are  
reported both seconds and as INR: 13

Instrumentation currently used for PT testing:

Manufacturer	Instrument	No. of Hospitals
Medical Laboratory Automation Pleasantville, NY	MLA (Models included: 700, 900, 900C, 1000C)	11/13
Ortho Diagnostic System Raritan, NJ	Koagulab 16S	1/13
ACL Instrumentation Laboratory Lexington, MA	IL ACL 3000	1/13

Reagents currently in use for PT testing:

Manufacturer	Reagent	ISI	No. of Hospitals
Baxter Diagnostics (DADE®) Miami, FL	Thromboplastin, C	2.5 - 2.9	6/13
	Thromboplastin, C Plus	1.9 - 2.1	2/13
	Innovin™	1.0	3/13
Ortho Diagnostic System Raritan, NJ	Ortho™ Brain Thromboplastin	1.8	1/13
ACL Instrumentation Laboratory Lexington, MA	IL-PT-FIB IL	2.5	1/13

The thromboplastin reagent anticipated to be used in 1995:

Manufacturer	Reagent	ISI	No. of Hospitals
Baxter Diagnostics (DADE®) Miami, FL	Thromboplastin, C Plus Innovin™	1.9 - 2.1	2/13
		1.0	7/13
Ortho Diagnostic System Lexington, MA	Ortho™ Brain Thromboplastin RecombiPlasTin™	1.8	1/13
		1.	2/13
ACL Instrumentation Laboratory Lexington, MA	IL-PT-FIB IL	2.5	1/13

Center, and Kent Davis, supervisor, Special Hematology Laboratory, Gunderson Clinic, LaCrosse, Wis. A panel discussion followed, monitored by Kenneth Ryder, M.D., Ph.D., chief of pathology and laboratory medicine, Wishard Memorial Hospital. Other panel members were: Preetham Jetty, M.D., a cardiologist at Community Hospital East; Larry Howie, MT (ASCP), manager of laboratory services at St. Vincent Hospitals, and the morning speakers, Dr. Triplett and Davis. Two points were considered: 1) the possibility of all Indianapolis hospital laboratories using a thromboplastin reagent with the same ISI; and 2) the way in which PT testing results should be reported, seconds, INR or both.

Technologists and pathologists in the audience participated in the discussion. Julie Hilderbrand, MT(ASCP), from University Hospital reported on an in-house comparative analysis of various thromboplastin reagents. A decision has been made at IU Medical Center, based on the data from this study, to switch to a

recombinant thromboplastin with ISI of 1. The coagulation laboratories of Community Hospital have recently switched thromboplastin reagents and are currently using a recombinant thromboplastin with ISI of 1. Representatives from Community Hospitals stressed that education of clinicians and laboratory personnel was crucial to the successful transition that they had experienced during change in reagents.

Conference participants agreed that the reagent of choice is a recombinant thromboplastin with an ISI of 1. All hospital laboratories in Indianapolis are reporting the results of PT testing both as INR and in seconds. The possibility of dropping the seconds and reporting only INR was discussed; however, participants decided both should continue to be reported.

This joint effort between the technologists and pathologists involved in coagulation testing within the major Indianapolis hospitals was highly successful and demonstrates the feasibility of future joint efforts between area

hospitals to improve patient care. □

*Dr. Danielson and Dr. Ryder are with the Indiana University Medical Center, and Howie is with St. Vincent Hospital and Health Services.*

*Correspondence: Constance F.M. Danielson, M.D., Ph.D., Indiana University Hospitals 4430, 550 N. University Blvd., Indianapolis, IN 46202-5283.*

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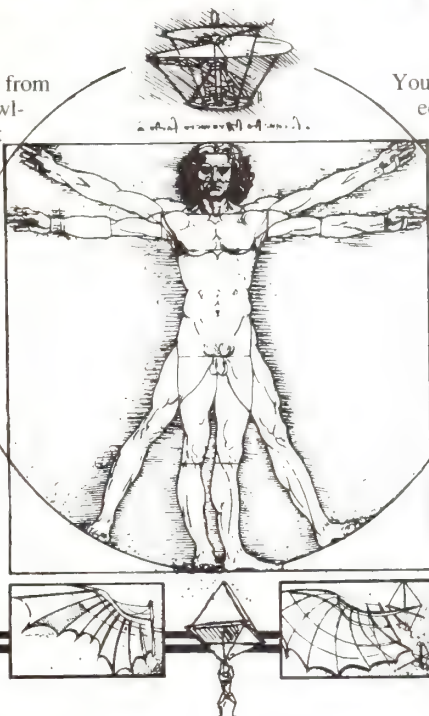
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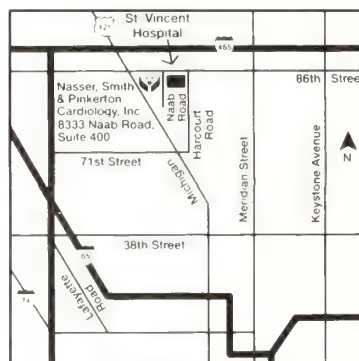


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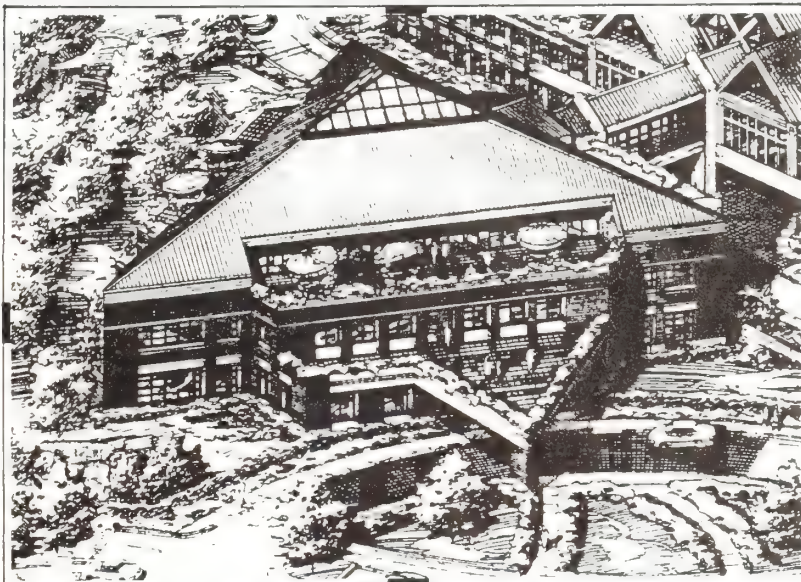
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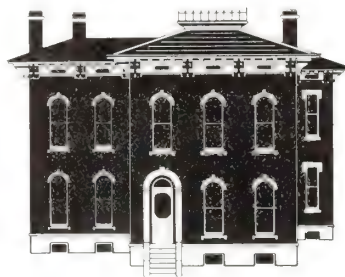
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## Task force recommends ways to boost membership

**Darlene Haddawi**  
ISMA Alliance President

**B**arbara Tippins of Dunwoody, Ga., took office as president of the American Medical Association Alliance last June. She includes in her programs a strong emphasis on the AMA Alliance's "One Choice:



**Tippins**

"One Voice" campaign to build the organization's membership. Mrs. Tippins said in her inaugural address, "I want this to be the first organization that every physician's spouse joins and the last organization they leave. It's time to emphasize what we have in common, instead of our differences, time to talk about what brings us together, instead of what pulls us apart. It's time to realize that our success depends on the willingness of all physicians' spouses to work together as a team, with our communities, our medical societies and our own members."

### AMA Alliance strategic plan

The AMA Alliance finds itself approaching the mid 1990s with a committed core of members and leaders but a declining nationwide membership.

The AMA Alliance Strategic Planning Task Force was appointed in 1993 to address this issue and chart ways to move the organization efficiently into the 21st century. The results of this task force revealed that the No. 1 concern for the Alliance is mem-

bership retention and growth. Named important to these efforts were a universal identity for all levels of the organization; a unifying health issue for the entire organization; nationwide media recognition; representation with government, health organizations and organized medicine; and legislative activity involving all members.

Nineteen recommendations were submitted by the task force to address these concerns. Three recommendations will directly affect county and state alliances:

#### Recommendation I:

- That effective July 1, 1995, national, state and county organizations be known as The Medical Alliance to establish universal identity, obtain national media coverage and promote ownership of the total organization by all members;
- That The Medical Alliance be used as follows: The Medical Alliance of the Indiana State Medical Association; and
- That an identifying signature that includes The Medical Alliance month logo and compatible typeface be issued to and used by The Medical Alliance at all levels and that the type be individualized to accommodate each state and county.

#### Recommendation II:

- That counties and states be encouraged to participate in a unifying national health promotion in addition to programs that meet local health needs;
- That prevention of family violence be the first national health promotion, under the name SAVE: Stop America's Violence Everywhere;
- That medical alliances be

urged to participate in SAVE TODAY, a violence-free day to be held on the second Wednesday in October, beginning Oct. 11, 1995; and

- That materials, including suggestions for gaining media coverage, be developed by national headquarters to give medical alliances specific ways to participate in SAVE TODAY.

#### Recommendation XVII:

- That July 1 to June 30 be established as the unified fiscal year for county, state and national medical alliances, beginning July 1, 1997;
- That a unified billing program and unified dues amount based on an average of the current total of county, state and national dues be established by July 1, 1998, through which national headquarters would bill every medical alliance member for dues; and
- That a national standing committee be assigned to work with states and counties to establish the unified dues amount and billing program in cooperation with national headquarters staff to begin with the 1998-99 fiscal year.

The above recommendations have been referred to the June 1995 AMA Alliance House of Delegates for action. Delegates from the ISMA Alliance who will attend this convention include: Darlene Haddawi, president; Valerie Gates, president-elect; Fran Foster, Cheryl Haslitt and Patty Lackey, area vice presidents; and Janice Leiphart, county representative.

For more information, call Darlene Haddawi at (812) 339-9092. The state delegation will vote based on the consensus of its members. □

## from the museum

Oren S. Cooley  
Indianapolis

The Indiana Medical History Museum will feature a viewing of Ray Cooney's hilarious comedy "Run for Your Wife" during the museum's third annual spring benefit this April.

This farce, which depicts the complications that occur as a taxi cab driver attempts to keep his two wives from meeting, will play three weekends at the Indianapolis Civic Theatre. The museum's benefit will include the performance on Friday, April 14.

A cocktail buffet will begin at 6 p.m. in the theater's Kitty Pantzer Room. The play will begin at 8 p.m.

In this farce, John Smith, a London taxi cab driver, must maintain two separate households, one in Wimbledon, the other in Streatham, because he has two wives. Neither wife knows of the other's existence.

His irregular work schedule allows Smith to get away with this lifestyle until an unusual accident forces his two worlds to collide. With increasing ineptitude, Smith attempts to keep the police from investigating his accident and prevent his wives from learning about his bigamous relationships.

To complicate the plot, almost everyone is mistaken for someone else, one wife for a nun, the other for a transvestite. Smith's cozy lifestyle begins to explode into smithereens as complication becomes entangled with complication in this hilarious farce.

Besides "Run for Your Wife" (1989), British playwright Ray Cooney has written "Out of Order" (1991), "It Runs in the Family" (1990) and "Move Over,

Mrs. Markham" (1972). He also worked on the 1975 film adaptation of his 1971 play, "Not Now, Darling."

Tickets for the third annual spring benefit will be \$50 per person. To purchase tickets, call the Indiana Medical History Museum at (317) 635-7329.

All proceeds will benefit the educational programs of the Indiana Medical History Museum, a private non-profit organization dedicated to preserving the heritage of the healing arts in Indiana. As the nation's oldest surviving pathology laboratory, the building that houses the museum originally provided physicians in the late 1800s and early 1900s with state-of-the-art facilities in which to study mental and nervous disorders.

Today, the museum uses its

more than 15,000 artifacts to create educational programs and tours that explore the developments that made possible today's advanced medical treatments and health care. Teachers across Indiana enable their students to experience the various educational programs either by visiting the museum or by scheduling the museum's staff for in-class visits.

Last year, nearly 4,000 people visited the Indiana Medical History Museum to enjoy the museum's educational programs or to tour the historic structure. Approximately one-half of that number were students, who came to learn about medicine during the Civil War, the ways the germ theory changed medical practices and the different concepts various societal cultures have proposed to treat people with mental illness. □



More fun than Lucy  
& Ethel in the  
chocolate factory!

# Run for Your Wife

By  
Ray Cooney  
author of  
"It Runs in the Family,"  
"Out of Order,"  
&  
"Move Over Mrs. Markham"

The museum's third annual spring benefit will feature Ray Cooney's hilarious comedy, "Run for Your Wife."



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## TRUSTEES (Terms end in October)

**District**  
 1 – Barney R. Maynard, Evansville (1995)  
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 3 – John Seward, Bedford (1997)  
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 5 – Fred E. Haggerty, Greencastle (1996)  
 6 – Ray A. Haas, Greenfield (1997)  
 7 – Ron Stegemoller, Danville (1995)  
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 9 – Stephen D. Tharp, Frankfort (1997)  
 10 – Thomas A. Brubaker, Munster (1995)  
 11 – Laurence K. Musselman, Marion (1996)  
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 \*13 – Alfred C. Cox, South Bend (1995)  
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**(Terms end in October)**  
**District**  
 1 – Bruce W. Romick, Evansville (1997)  
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 3 – Daniel Cannon, New Albany (1995)  
 4 – Lawrence R. Bailey Jr., Aurora (1997)

5 – Fred Drake, Terre Haute (1997)  
 6 – Howard C. Deitsch, Richmond (1995)  
 7 – Frank Johnson, Indianapolis (1995)  
 7 – Paula A. Hall, Mooresville (1997)  
 7 – Girdhar Ahuja, Indianapolis (1996)  
 8 – Susan K. Pyle, Union City (1997)  
 9 – Daniel Berner, Lafayette (1995)  
 10 – John L. Swarner, Valparaiso (1997)  
 11 – Regino B. Urgena, Marion (1995)  
 12 – Scott Wagner, Fort Wayne (1995)  
 13 – Richard J. Houck, Michigan City (1997)  
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 John A. Knot, Lafayette (1996)  
 Shirley Khalouf, Marion (1996)  
 William Beeson, Indianapolis (1996)

## AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Barney Maynard, Evansville (1995)  
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 Max N. Hoffman, Covington (1996)  
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## DISTRICT OFFICERS & MEETINGS

1 - Pres: Mariellen Dentino, Evansville  
 Secy: Dean Beckman, Jasper  
 Annual Meeting: May 18, 1995  
 2 - Pres: Gene Bourgasser, Sullivan  
 Secy: E. Steve Du Pre, Sullivan  
 Annual Meeting: May 11, 1995  
 3 - Pres: Daniel Cannon, New Albany  
 Secy: C. Montgomery Hocker, New Albany  
 Annual Meeting: May 17, 1995  
 4 - Pres: Alan Kohlhaas, Lawrenceburg  
 Secy: Gerald Bowen, Lawrenceburg  
 Annual Meeting: May 3, 1995  
 5 - Pres: Warren Macy, Greencastle  
 Secy: Rahim Farid, Brazil  
 Annual Meeting: May 25, 1995  
 6 - Pres: Helen Steussy, New Castle  
 Secy: to be announced  
 Annual Meeting: May 10, 1995  
 7 - Pres: Craig Moorman, Franklin  
 Secy: John Schneider, Indianapolis  
 Annual Meeting: to be announced

8 - Pres: Kathleen A. Galbraith, Portland  
 Secy: Mark A. Haggenjos, Portland  
 Annual Meeting: June 7, 1995  
 9 - Pres: Herschell Servies, Lebanon  
 Secy: Stephen D. Tharp, Frankfort  
 Annual Meeting: June 14, 1995  
 10 - Pres: Frank Hieber, Munster  
 Secy: Floyd Manley, Hammond  
 Annual Meeting: April 29, 1995  
 11 - Pres: Agnes Kenny, Peru  
 Secy: Jack Higgins, Kokomo  
 Annual Meeting: Sept. 13, 1995  
 12 - Pres: Joseph Manthey, Liberty Center  
 Secy: David Haines, Warsaw  
 Annual Meeting: Sept. 14, 1995  
 13 - Pres: Donald Smith, South Bend  
 Secy: John W. Schurz, South Bend  
 Annual Meeting: March 22, 1995

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 Janna Kosinski, *Field Services (Southern)*  
 Barbara Walker, *Practice Management Consultant*  
 Meg Patton, *Practice Management Consultant*  
 Tom Martens, *Members Health Insurance*  
 Tina Sims, *Indiana Medicine*

## ■ cme calendar

### Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology Inc. will present the following CME courses in 1995:

- Apr. 28** - Progress in Cardiology VIII, Westin Hotel, Indianapolis.
- Aug. 23** - Practice Management Seminar, Ritz Charles, Indianapolis.
- Nov. 3** - Emergency Physician Seminar, Ritz Charles, Indianapolis

For registration information, call Janet MacAbee at (317) 338-6089.

### HIV Update

Reid Hospital in Richmond will sponsor an evening seminar titled "HIV Update" May 23.

For registration information, call Marie Hopper, (317) 983-3112.

### Biliary, Pancreatic Disease

The Fourth International "Hands-On" Therapeutic ERCP Conference will be held June 2 through 4 at the Baltimore Marriott Inner Harbor hotel in Baltimore. This year's topic is a "Didactic and Hands-On Therapeutic Orientation to Biliary and Pancreatic Disease." Maurice Arregui, M.D., of Indianapolis is the course co-director.

The conference is endorsed by the Society of American Gastrointestinal Endoscopic Surgeons. For more information, call Education Design at 1-800-832-5115.

### University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Mar. 30-31** - Challenges and Changes in Obstetrics and Gynecology, Towsley Center, Ann

Arbor, Mich.

- Apr. 1** - Transvaginal Ultrasound Workshop, Towsley Center, Ann Arbor, Mich.

- Apr. 5-7** - Ultrasound in Obstetrics and Gynecology, Towsley Center, Ann Arbor, Mich.

- Apr. 6-9** - The Multimodality Treatment of Breast Cancer, Pinehurst Resort and Country Club, Pinehurst, N.C.

- Apr. 24-28** - 23rd Annual Spring Update: Advances in Internal Medicine, Towsley Center, Ann Arbor, Mich.

- July 9-12** - 21st Annual Mackinac Island Course: Advances in the Management of Infectious Diseases, Grand Hotel, Mackinac Island, Mich.

For registration information, call Vivian Woods at (313) 763-1400.

### University of Wisconsin

The University of Wisconsin will sponsor these CME courses:

- May 5-6** - Geriatrics Clinical Update, Edgewater Hotel, Madison, Wis.
- May 11-13** - 18th Annual Sports Medicine Symposium, Holiday Inn West, Madison, Wis.

For more information, call Sarah Aslakson, (608) 263-2856.

### George Washington

The George Washington University Medical Center in Washington, D.C., will sponsor these CME courses:

- Mar. 31** - Reflux and Ulcer

Disease: Advanced Laparoscopy Course, George Washington University Medical Center, Ross Hall, Washington, D.C.

- June 7-9** - Third International Symposium on Maritime Health, Maritime Institute of Technology and Graduate Studies, Baltimore.

- June 7-10** - Second Annual Intensive Review of Internal Medicine, Washington Marriott Hotel, Washington, D.C.

- June 17-21** - 17th National Lesbian and Gay Health Conference and 13th Annual AIDS/HIV Forum, Hyatt Regency, Minneapolis.

- June 24-28** - Third Annual Board Review in Family Medicine, Marriott Crystal Gateway Hotel, Arlington, Va.

For more information, call (202) 994-4285. □

### How to submit CME news

To publish news of your CME courses, mail information to *Indiana Medicine*, 322 Canal Walk, Indianapolis, IN 46202-3268 or fax it to (317) 261-2076. News is due two months before publication (e.g., Jan. 20 for the March/April issue). □

# Breast-Conservation Treatment



## *AT LEAST ONE-THIRD OF ALL BREAST CANCER PATIENTS COULD HAVE LUMPECTOMY FOLLOWED BY RADIATION THERAPY*

The American Cancer Society, the American College of Surgeons and the American College of Radiology have agreed that women whose early breast cancer was detected by mammography are candidates for breast-saving treatment. This treatment consists of lumpectomy with axillary node sampling followed by radiation therapy to the breast. According to new standards, women with small lumps, those with tumors as large as two inches, and even some women with positive nodes may be candidates for this treatment.

The purpose of the breast-conserving treatment is to treat these patients adequately but with a good cosmetic result. Stage for stage, patients treated in this manner have the same longevity and the same freedom from local recurrence as those treated with mastectomy.

For copies of the standards please contact Keri Sperry, American College of Radiology, 1891 Preston White Drive, Reston, VA 22091.





## ■ news briefs

### **IU studies Medicaid reform in Oregon**

Investigators at Indiana University have been awarded a contract by the U.S. Health Care Financing Administration to evaluate Oregon's Medicaid Reform Demonstration. The study will include investigators from the Bowen Research Center, the IU School of Medicine, the IU School of Public and Environmental Affairs and the Regenstrief Institute.

The five-year, \$3.2 million project is being conducted jointly with Health Economics Research, Inc., in Waltham, Mass., and Research Triangle Institute in North Carolina.

The Oregon demonstration, implemented in 1994, expands Medicaid eligibility to all uninsured residents below the federal poverty level. The expansions will be funded both through increased use of managed care and the prioritization of Medicaid services based on their net health benefits. Medicaid no longer covers low priority services, many of which are believed to be of little medical value.

The IU team will investigate the effects of the program on quality of and access to care, satisfaction with the program and employer responses to the program. One of the study goals is to determine how the priority list is implemented and how clients and providers are affected when certain services are not covered.

### **National rural health conference scheduled**

The National Rural Health Association will hold its annual conference May 17-20 at the Hyatt Regency Hotel in Atlanta. "Rural

Health – Harnessing the Winds of Change" is the theme of the conference, which will focus on helping rural health care providers and systems deal with the changing trends in rural health care brought about by the national health reform debate.

For more information, contact the NRHA National Service Center, One W. Armour Blvd., Suite 301, Kansas City, MO 64111, (816) 756-3140.

### **Survey reveals pay for physician executives**

What is the typical compensation of physician health care executives? What factors influence actual pay? What percent of a physician executive's time is spent in management? A survey by the American College of Physician Executives revealed the answers to these and other questions about compensation.

Here are some of the findings:

- The median 1994 total compensation (salary plus bonus and incentive) for participants who spend 100% of their time in management was \$166,000.
- The median 1994 total compensation for all survey participants for management activities was \$145,000, with the average time spent in management at 71%.
- The highest paying organizations are, in descending order, health care systems, managed care organizations, private industry, academic health care, hospitals, integrated medical groups and IPAs.
- Top management is consistently paid higher than senior medical management and department/division heads across all organization types.

The survey found that the primary factors influencing actual pay are management level, title or function, percent of time spent in management, years in management, industry sector or type of organization and, to some extent, geographic location.

The results of the survey are available to ACPE members for \$195 and non-members for \$395. For information, call Scott Gordon, Hay Management Consultants, (510) 945-8220.

### **Free packet covers immunization guidelines**

The American Medical Association, working with the Centers for Disease Control and Prevention, has developed an educational packet on immunizations that is now available to physicians. The packet, titled "Make Sure They're Covered," contains information on the following:

- the Vaccines for Children program;
- the updated recommended immunization schedule;
- Standards for Pediatric Immunization Practices;
- vaccines in development;
- vaccines for older adults;
- vaccines for immunocompromised patients; and
- the National Vaccine Injury Compensation Program.

Also included are the CDC "Guide to Contraindications to Childhood Vaccinations" and additional references and useful phone numbers. The project's expenses are funded through a grant from the CDC.

The kits are available free by calling 1-800-621-8335 and requesting product number NCO15895. The information kit includes a toll-free number for follow-up calls. ▽

## ISMA announces 1995 practice management seminars

The ISMA will sponsor 21 practice management seminars throughout the state. The schedule includes nine new seminars, and the remaining programs have been updated for 1995. Physicians, medical group managers and office personnel are invited to attend.

New programs for 1995 include the following:

- Medical Terminology. This workshop will introduce basic medical terminology emphasizing terms commonly used for insurance claims and coding.
- Making 'Cents' of Reimbursement Methods – How to Use Today's Payment Methods to Understand and Improve the Business of Your Practice. Cambridge Health Economics Group, which includes key members of the Harvard research team that created the resource-based relative value scale, will provide advice on how to answer important questions about your practice: How am I paid for my professional services? Are my payments enough? What is my practice worth? Participants will receive a model for evaluating the economic worth of a practice and the financial, legal or practice management implications of a merger, affiliation or acquisition.
- CPT/ICD-9 Coding Update 1996. The course will provide information about the changes in the ICD-9-CM diagnosis coding and CPT-4 procedure coding systems for 1996.
- The Business of Practicing Medicine – It's Tougher Than Ever: Legal and Financial Issues Analyzed. Representa-

tives from a law firm and CPA firm will present four full-day workshops. Workshop topics are "Market Reform/Managed Care Penetration in Indiana," "Federal Regulations That Can Kill Your Practice," "Consolidation and Integration of Practices," and "Managed Care Generally."

- Legal Guidelines for Health Care Records. This seminar will cover the legal aspects of medical record retention, confidentiality, security, ownership and disclosure.
- Medical Practice Automation: A Necessary Part of Your Survival Strategy. The seminar will cover ways to improve practice through the use of technology, a step-by-step approach to select, implement and maintain computerized business records.

The complete schedule of workshops is:

- Building a Successful Medical Practice – ABCs of Practice Management: June 22 and Aug. 17, ISMA headquarters, Indianapolis.
- The Business Side of Practicing Medicine: Market Reform/Managed Care, May 24, Radisson Plaza Hotel, Indianapolis; Federal Regulations That Can Kill Your Practice, Aug. 9, Norman's at Union Station, Indianapolis; Consolidation and Integration of Practices, Aug. 23, Radisson Plaza Hotel, Indianapolis; and Managed Care, Oct. 4, Radisson Star Plaza, Merrillville.
- CPT-4 Procedure Coding: Sept. 28 and Dec. 14, ISMA headquarters, Indianapolis.
- CPT/ICD-9 Coding Update 1996: Dec. 15, ISMA headquar-

ters, Indianapolis.

- ICD-9-CM Diagnosis Coding: Sept. 27 and Dec. 13, ISMA headquarters, Indianapolis.
  - Legal Guidelines for Health Care Records: June 14, Marriott, Indianapolis, and Oct. 11, Norman's at Union Station, Indianapolis.
  - Making "Cents" of Reimbursement Methods: June 28, Adams Mark Hotel, Indianapolis.
  - Mastering Medicaid: April 5, Ramada Hotel Riverside, Jeffersonville; April 6, Holiday Inn, Evansville; April 12, Radisson Star Plaza, Merrillville; April 13, Marriott, Fort Wayne; April 18, Best Western Waterfront Plaza, Indianapolis.
  - Medical Practice Automation: Sept. 13, Holiday Inn Airport, Indianapolis.
  - Medical Terminology: Sept. 20, ISMA headquarters, Indianapolis.
  - Medicare 101: June 21 and Aug. 16, ISMA headquarters, Indianapolis.
  - Medicare Updates for 1996: Dec. 6, Ramada Hotel Riverside, Jeffersonville; Dec. 7, Holiday Inn, Evansville; Dec. 12, Best Western Waterfront Plaza, Indianapolis; Dec. 19, Radisson Star Plaza, Merrillville; Dec. 20, Marriott, Fort Wayne.
  - Specialty Coding Rap Sessions: May 3, Primary care, family practice, internal medicine; May 4, ob/gyn; May 5, dermatology; May 17, cardiology; May 18, orthopaedics; and May 19, urology, all at ISMA headquarters in Indianapolis.
- For registration information, call Meg Patton or Barbara Walker, (317) 261-2060 or 1-800-257-4762. □

## ■ obituaries

### **James M. Burk, M.D.**

Dr. Burk, 80, a retired general practitioner, died Nov. 20, 1994, at his home in Decatur.

He was a 1938 graduate of the Duke University School of Medicine.

Dr. Burk retired in 1994, after 54 years in practice. He was the health columnist for *Modern Maturity Magazine* for many years. He served on the Decatur and North Adams Community School Boards, was an honorary Kentucky Colonel and was the first Eagle Scout in Adams County.

### **James O. Conklin, M.D.**

Dr. Conklin, 86, a retired Terre Haute surgeon, died Dec. 14, 1994, at Meadows Manor Convalescent and Rehabilitation Center in Terre Haute.

He was a 1934 graduate of the University of Illinois School of Medicine and an Army Medical Corps veteran of World II.

Dr. Conklin practiced medicine for more than 50 years, serving both St. Anthony Hospital and Terre Haute Regional Hospital. He was a member of the International College of Surgeons and the American Thyroid Association.

### **Antolin Montecillo, M.D.**

Dr. Montecillo, 70, a Clinton family physician, died Dec. 24, 1994, at Terre Haute Regional Hospital.

He was a 1953 graduate of the College of Medicine, University of the Philippines in Manila. During World War II, he served with the U.S. Allied Forces as a Philippines national.

Dr. Montecillo was a member of the Indiana/Philippine Medical Association and served as medical adviser for the Lions State Cancer Control. He was a past president of the Clinton Lions Club and was Lion of the Year in 1980.

### **Ian S. Templeton, M.D.**

Dr. Templeton, 65, a retired Seymour surgeon, died Dec. 19, 1994.

He was a 1957 graduate of the Indiana University School of Medicine.

Dr. Templeton had served on the board of directors of the Seymour Boys Club and the Greater Seymour Chamber of Commerce.

### **Elmer S. Zweig, M.D.**

Dr. Zweig, 82, a Fort Wayne physician specializing in the treatment of alcoholism and substance abuse, died Dec. 13, 1994, at his home.

He was a 1936 graduate of the Indiana University School of Medicine and an Air Force medical corps veteran of World War II.

Dr. Zweig practiced general medicine, surgery and obstetrics, but his specialty in later years was the treatment of alcoholism and substance abuse. He was the medical director of Washington House from 1973 to 1992. He helped form the emergency department of Parkview Memorial Hospital and the hospital's alcoholic treatment center. He served on many boards of medical, child health, mental health and elder care facilities and lectured on alcohol and substance abuse during medical conferences in the United States and in foreign countries. He was named a Sagamore of the Wabash in 1985 and was given a Distinguished Public Service Award by the Indiana Academy of Family Physicians in 1992. □



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**AMWA**  
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MEDICAL WRITERS  
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Two Indiana anesthesiologists were elected to national office



Dr. Stoelting



Dr. Glazer

in the American Society of Anesthesiologists at its annual meeting. **Dr. Robert Stoelting**, chairman of the department of anesthesiology at the Indiana University School of Medicine, was elected vice president for scientific affairs. **Dr. Barry Glazer**, chairman of the department of anesthesiology at St. Francis Hospital in Beech Grove, was elected speaker of the house of delegates; he previously served four terms as vice speaker. **Dr. Larry Thompson**, South Bend, succeeds Dr. Stoelting as Indiana's district director on the ASA board of directors.

**Dr. Steven R. Smith**, director of occupational health and medicine for Community Hospitals Indianapolis, spoke at the Indiana State Chamber of Commerce Annual Worker's Compensation Conference. His topic was "The Most Common Worker's Comp Injury: Occupational Back Pain – Causes and Prevention Strategies."

**Dr. Debra J. Myers**, an Indianapolis pulmonologist, discussed pulmonary health concerns on the WFYI-Channel 20 broadcast of "A Woman's Health: A Talk with the Experts."

### Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

#### November 1994

Blusys, Paul V., Leo  
Brogan, Thomas M., Indianapolis  
Fields, Max L., Monticello  
Klootwyk, Thomas E., Indianapolis  
Kurtz, Richard, Indianapolis  
Lievertz, Randolph W., Indianapolis  
Link, William C., Bloomington  
Ochsner, Edward C., Danville  
Reising, Gabriel E., Muncie  
Romain, Louis F., Fort Wayne  
Tharp, Morgan E., Indianapolis

Wdowka, Steven E., Kokomo  
Wernert, John J., Indianapolis

#### December 1994

Acosta, Constancio B., Hobart  
Bisson, Kenneth A., Angola  
Brennan, Thomas F., Lafayette  
Emkes, Bernard J., Indianapolis  
Frieske, David A., Valparaiso  
Haslitt, Joseph H., Muncie  
Mouser, Robert W., Indianapolis □

**Dr. Rudy Kachmann**, a Fort Wayne neurosurgeon, has made a major gift that allowed the completion of the auditorium at Lutheran Hospital. To honor his generosity, the facility has been named the Kachmann Auditorium. Dr. Kachmann donated the funds because of his dedication to education and to the hospital.

**Dr. Stephen W. Perkins** and **Dr. A. Michael Sadove** of the Meridian Plastic Surgery Center in Indianapolis spoke at the seminar on "Latest Advances in Cosmetic Facial Procedures" sponsored by the American Academy of Facial Plastic and Reconstructive Surgery in Beaver Creek, Colo. Dr. Perkins moderated a panel discussion on "Transconjunctival Lower Lid Blepharoplasty" and was a panel member for discussions on "Rehabilitation of the Forehead and Brows," "Nuances in Facelifting" and "Chemical Peels." Dr. Sadove was a panelist for discussions on

"Pearls in Management of Difficult Nasal Surgery Dilemmas" and "Cosmetic Augmentation of the Face."

**Dr. Richard D. Zeph**, a Carmel facial plastic surgeon, was a speaker and panelist at the Facial Plastic Surgery Seminar held at University Place Conference Center in Indianapolis. He spoke on "SMAS Imbrication Rhytidectomy with Long Skin Flap vs. Deep Plane Facelift," "Perioral and Lip Rejuvenation Use of Gortex Grafting" and "Nasal Profile Augmentation and Lengthening." He also was a panelist on a discussion of "Controversies on Skeletal Facial Surgery" and was a moderator for a panel discussion of "Controversies in Aging Face Surgery."

Several Indiana surgeons are participating in a nationwide program that provides free facial and plastic reconstructive surgery to victims of domestic violence.



The American Academy of Facial Plastic and Reconstructive Surgery and the National Coalition Against Domestic Violence created the National Domestic Violence Project to help women break out of the cycle of violence, enhance their self-esteem and rebuild their lives. Participating Indiana physicians include **Dr. William H. Beeson**, **Dr. Stephen W. Perkins**, **Dr. Bruce Sterman** and **Dr. Richard Zeph**, all of Indianapolis, and **Dr. Charles Giffin** and **Dr. David W. Stein**, both of Fort Wayne.

**Dr. Maurice Arregui**, an Indianapolis surgeon, spoke on laparoscopic hernia repair and advanced laparoscopic surgical procedures at the meeting of the Ecuadorian Society of Laparoscopic Surgery and was given an honorary membership in the society. He participated in a teleconference during an international course on laparoscopic inguinal hernia repair at the University Hospital, Maastricht, The Netherlands. Dr. Arregui was co-author of a paper on "Complications and Recurrences Associated with Laparoscopic Repair of Groin Hernias: A Multi-institutional Retrospective Analysis" in *Surgical Endoscopy*.

**Dr. Thierry Wilbrandt**, an Indianapolis ophthalmologist, presented a paper on "Complications and Enhancement Strategies for Radial Keratotomy" at the meeting of the American Academy of Ophthalmology in San Francisco. He also helped teach the academy's radial keratotomy course and wet lab.

**Dr. Tony L. Yeiter**, chief pathologist at AMI Culver Union Hospital in Crawfordsville, has been board certified in cytopathology.

**Dr. James Buechler** of Terre

Haute received the annual Union Hospital Foundation Weinbaum Award. Dr. Buechler is director of the hospital's Family Practice Center and the Midwest Center for Rural Health and is a former member of the editorial board of *Indiana Medicine*. The award is given to a member of the hospital's medical or dental staff who has carried on the tradition of excellence exemplified by the late Dr. Jack Weinbaum.

The following physicians have been initiated into Fellowship of the American College of Surgeons: **Dr. Michael D. Levine** and **Dr. John S. Pittman**, both of Carmel; **Dr. Patrick A. Cleary** and **Dr. Kurt W. Sprunger**, both of Muncie; and **Dr. S. Campbell Gabrielson**, Greenfield.

**Dr. J. Craig Hutchison** has retired from Caylor Nickel's West Jay Clinic in Dunkirk, where he has practiced since 1978. He will continue to practice part-time as an emergency physician.

#### New ISMA members

**Nancy J. Albright**, M.D., Richmond, pediatrics.

**Buland I. Ashraf**, M.D., Indianapolis, internal medicine.

**Allan J. Berger**, M.D., Charlestown, anesthesiology.

**Terrell M. Bond Jr.**, M.D., Fort Wayne, obstetrics and gynecology.

**Sally A. Booth**, M.D., Indianapolis, dermatology.

**Donald R. Brake**, M.D., Evansville, family practice.

**Craig E. Buckles**, M.D., Muncie, psychiatry.

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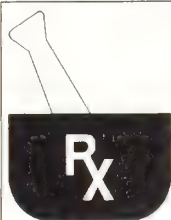
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**VOLTAREN®**  
diclofenac sodium  
Delayed-Release (enteric-coated) Tablets

**CATAFLAM®**  
diclofenac potassium  
Immediate-Release Tablets

Brief Summary (For full Prescribing Information, see Package Insert.)

**INDICATIONS AND USAGE**

Voltaren Delayed-Release or Cataflam Immediate-Release Tablets are indicated for the acute and chronic treatment of signs and symptoms of rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis. Only Cataflam is indicated for the management of pain and primary dysmenorrhea, when prompt pain relief is desired, because it is formulated to provide earlier plasma concentrations of diclofenac (see CLINICAL PHARMACOLOGY, Pharmacokinetics and Clinical Studies).

**CONTRAINDICATIONS**

Diclofenac in either formulation (Voltaren or Cataflam) is contraindicated in patients with hypersensitivity to diclofenac. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactoid-like reactions to diclofenac have been reported in such patients.

**WARNINGS**

**Gastrointestinal Effects**

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac, even in the absence of previous GI tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

**Risk of GI Ulcerations, Bleeding, and Perforation with NSAID Therapy:** Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous GI tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper GI ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal GI events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity.

**Hepatic Effects**

As with other NSAIDs, elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [i.e., the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 4 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Based on this experience, if diclofenac is used chronically, the first transaminase measurement should be made no later than 8 weeks after the start of diclofenac treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if system c manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued.

To minimize the possibility that hepatic injury could become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action on patients should take if these signs and symptoms appear.

**PRECAUTIONS**

**General**

**Allergic Reactions:** As with other NSAIDs, allergic reactions including anaphylaxis have been reported with diclofenac. Specific allergic manifestations consisting of swelling of eyelids, lips, pharynx, and larynx; urticaria; asthma, and bronchospasm, sometimes with a concomitant fall in blood pressure (severe at times) have been observed in clinical trials and/or in the marketing experience with diclofenac. Anaphylaxis has rarely been reported from foreign sources, in U.S. clinical trials with diclofenac on over 6000 patients. 1 case of anaphylaxis was reported. In controlled clinical trials, allergic reactions have been observed at an incidence of 0.5%. These reactions can occur without prior exposure to the drug.

**Fluid Retention and Edema:** Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

**Renal Effects:** As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of papillary necrosis was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (120-1200 mg/kg) in several bioassay subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

**Porphyria:** The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

**Information for Patients**

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

**Laboratory Tests**

Because serious GI tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, Risk of GI Ulcerations, Bleeding, and Perforation with NSAID Therapy). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac; these symptoms may become evident between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects).

**Drug Interactions**

**Aspirin:** Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

**Anticoagulants:** While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

**Digoxin, Methotrexate, Cyclosporine:** Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be

**monitored.**

**Lithium:** Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

**Oral Hypoglycemics:**

Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experience of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

**Diuretics:** Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

**Other Drugs:** In small groups of patients (7-10) interacting on study, the concomitant administration of azathioprine, gold, chloroquine, D-penicillamine, prednisolone, doxycycline, or digoxin did not significantly affect the peak levels and AUC values of diclofenac.

**Protein Binding**

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlorfentanyl, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence in vitro on the protein binding of diclofenac in human serum.

**Drug/Laboratory Test Interactions**

**Effect on Blood Coagulation:** Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII. Statistical significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree, therefore, patients who may be adversely affected by such an action should be carefully observed.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day or (12 mg/m<sup>2</sup>/day approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m<sup>2</sup>/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m<sup>2</sup>/day) in males and 1 mg/kg/day (3 mg/m<sup>2</sup>/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in *in vitro* point mutation assays in mammalian (mouse lymphoma) and microbial (yeast Ames) test systems and was nonmutagenic in several mammalian *in vivo* and *in vitro* tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m<sup>2</sup>/day) did not affect fertility.

**Teratogenic Effects**

There are no adequate and well-controlled studies in pregnant women. Diclofenac should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus.

**Pregnancy Category B:** Reproduction studies have been performed in mice given diclofenac sodium up to 20 mg/kg/day or 60 mg/m<sup>2</sup>/day and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 60 mg/m<sup>2</sup>/day for rats, and 80 mg/m<sup>2</sup>/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

**Labor and Delivery**

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during pregnancy should be avoided and, as with any other nonsteroidal anti-inflammatory drug, it is possible that diclofenac may inhibit uterine contraction.

**Nursing Mothers**

Diclofenac has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, diclofenac is not recommended for use in nursing women.

**Pediatric Use**

Safety and effectiveness of diclofenac in children have not been established.

**Geriatric Use**

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

**ADVERSE REACTIONS**

Adverse reaction information is derived from blinded, controlled and open-label clinical trials, as well as worldwide marketing experience. In the description on below, rates of more common events represent clinical study results; rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In a 6-month, double-blind trial comparing Voltaren Delayed-Release Tablets (N=197) vs. Cataflam Immediate-Release Tablets (N=196) vs. ibuprofen (N=197), adverse reactions were similar in nature and frequency. In 718 patients treated for shorter periods, i.e., 2 weeks or less, with Cataflam Immediate-Release Tablets, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods.

The incidence of common adverse reactions, greater than 1%, is based upon controlled clinical trials in 1543 patients treated for up to 13 weeks with Voltaren Delayed-Release Tablets. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or GI bleeding occurred in patients in 0.6% (95% confidence interval 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%). Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

**Incidence Greater Than 1% - Causal Relationship Probable:** (All derived from clinical trials.)

**Body as a Whole:** Abdominal pain or cramps, headache, fluid retention, abdominal distention.  
**Digestive:** Diarrhea, indigestion, nausea, constipation, flatulence, liver test abnormalities, \*PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

**Nervous System:** Dizziness.

**Skin and Appendages:** Rash, pruritus.

**Special Senses:** Tinnitus.

\*Incidence, 3% to 9% (incidence of unmarked reactions is 1%-3%).

**Incidence Less Than 1% - Causal Relationship Probable:** (The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

**Body as a Whole:** Malaise, swelling of lips and tongue, photosensitivity, anaphylaxis, anaphylactoid reactions.

**Cardiovascular:** Hypertension, congestive heart failure.  
**Digestive:** Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, hepatic necrosis, appetite change, pancreatitis with or without concomitant hepatitis, colitis.

**Hemic and Lymphatic:** Hemoglobin decrease, leukopenia, thrombocytopenia, hemolytic anemia, aplastic anemia, agranulocytosis, purpura, allergic purpura.

**Metabolic and Nutritional Disorders:** Azotemia.

**Nervous System:** Insomnia, drowsiness, depression, diplopia, anxiety, irritability, aseptic meningitis.

**Respiratory:** Epistaxis, asthma, laryngeal edema.

**Skin and Appendages:** Alopecia, urticaria, eczema, dermatitis, bullous eruption, erythema multiforme major, angioedema, Stevens-Johnson syndrome.

**Special Senses:** Blurred vision, taste disorder, reversible hearing loss, scotoma.

**Urogenital:** Nephrotic syndrome, proteinuria, oliguria, interstitial nephritis, papillary necrosis, acute renal failure.

**Incidence Less Than 1% - Causal Relationship Unknown:** (Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

**Body as a Whole:** Chest pain.

**Cardiovascular:** Palpitations, flushing, tachycardia, premature ventricular contractions, myocardial infarction.

**Digestive:** Esophageal lesions.

**Hemic and Lymphatic:** Bruising.

**Metabolic and Nutritional Disorders:** Hypoglycemia, weight loss.

**Nervous System:** Paresthesia, memory disturbance, nightmares, tremor, tic, abnormal coordination, convulsions, disorientation, psychotic reaction.

**Respiratory:** Dyspnea, hyperventilation, edema of pharynx.

**Skin and Appendages:** Excess perspiration, exfoliative dermatitis.

**Special Senses:** Vitreous floaters, night blindness, amblyopia.

**Urogenital:** Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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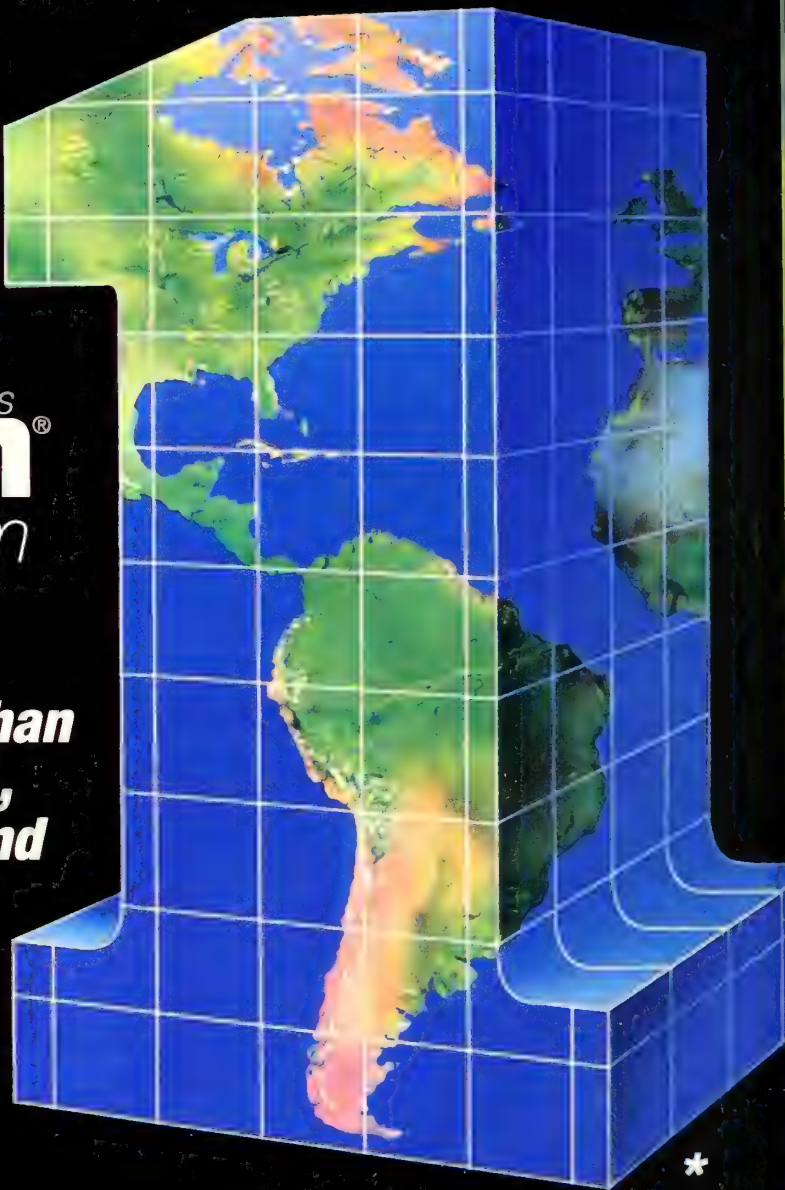


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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

May/June 1995

Vol. 88, No. 3



**Domestic violence**  
**A health concern**



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The Journal of the Indiana State Medical Association

May/June 1995

Vol. 88, No. 3

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## **EDS trying to resolve problems with Medicaid reimbursement**

Representatives from the ISMA met recently with EDS officials to discuss physicians' complaints about problems with Medicaid reimbursement. EDS said that the new AIM (Advanced Information Management) System that began operation in February has the capacity of making 48 separate edits, significantly more than the previous system could do. This improved capability has caused the system to reject many claims submitted by providers that in the past would have been paid. For example, if under the old system the provider left a blank in the space requesting information about the type of office setting the service was provided in, the claim would have been paid. Under the new system, these claims are rejected.

Problems with the failure of the new system to pick up the proper number of service days are being corrected. For example, the system had been paying for only one day instead of five when the service was billed as March 1 through 5.

EDS also said the high volume of calls – 240,000 in one month compared to the usual 60,000 – has caused busy signals and delays in responding.

In the Indiana House, complaints from doctors about Medicaid prompted the Public Health Committee to hold two hearings requiring the state Office of Medicaid Planning and Policy and EDS, the carrier, to own up to problems in the system. During the testimony, EDS admitted being sanctioned five times since July 1994 by the Family and Social Services Administration for not meeting the terms of their Medicaid contract. The sanctions carried fines of \$758,000. This had been previously unreported.

## **HCFA says 'no' to single payment locality request**

The Health Care Financing Administration (HCFA) has notified the ISMA that Indiana will not be designated a single, statewide payment locality for Medicare reimbursement for 1996. The ISMA was pursuing the change from three payment localities to one in response to Resolution 94-28, which cited "unfairly lower" RBRVS Medicare reimbursement for rural areas. The difference in reimbursement is estimated to be .05% after taxes and overhead expenses.

Although the ISMA mailed notices to all specialty societies and county medical societies requesting letters of support for or opposition to a statewide payment locality designation, there was no overwhelming majority of support from the respondents. No response was viewed as a negative.

The Urban Institute is conducting a study for HCFA regarding the multiple payment localities, and HCFA may elect to make changes in 1996 apart from individual state efforts. ■

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<b>1,000</b>	<ul style="list-style-type: none"> <li>\$1,000 calendar year deductible, \$2,000 per family</li> <li>Stop-Loss limit \$5,000 per person, \$10,000 per family</li> </ul>	✓	✓		
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<b>500PPN</b>	<ul style="list-style-type: none"> <li>\$250 calendar year deductible, \$500 per family</li> <li>Stop-Loss limit \$5,000 per person, \$10,000 per family</li> </ul>	✓	✓		✓

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## IU-Methodist consolidation does not include medical school

George T. Lukemeyer, M.D.  
Indianapolis

On March 9 the trustees of Indiana University and the board of directors of the Methodist Health Group announced an agreement in principle to join the University Hospitals (University Hospital and the James Whitcomb Riley Hospital for Children) and the Methodist Hospital of Indiana, Inc. The as yet unnamed, new organization will be a private not-for-profit corporation governed by one board of directors and a single management team with representatives from both Indiana University and Methodist. The dean of the Indiana University School of Medicine will be responsible for the research and medical education activities of this new entity. This includes all educational programs for medical students, residents, fellows and continuing medical education.

The Indiana University School of Medicine is **not** a part of this consolidation. Concerns were raised regarding potential adverse affects of the consolidation on Wishard Memorial Hospital. Indiana University and Methodist asserted that the long and mutually beneficial relationships between the IU School of Medicine, Wishard Memorial Hospital and the Veterans Administration Hospital should not be affected. Dean Walter J. Daly, M.D., was emphatic in his statement of dedication to maintaining and enhancing the long history of cooperation between the IU School of Medicine and Wishard Memorial Hospital.

Dr. Daly, at a general meet-

ing of the School of Medicine faculty, reviewed the genesis of the decision to consolidate University Hospitals and Methodist and detailed the lengthy and complex process of approval required for implementation of this agreement. Dr. Daly reminded the faculty that the provision of health care has become increasingly market driven. The escalating emphasis of market driven initiatives portends ever-increasing numbers of patients enrolled in managed care and/or capitated health care plans. Hospitals, insurance companies and HMOs are aggressively pursuing networking arrangements and agreements. Many area hospitals, including Methodist and the University Hospitals, have explored partnerships with other Indiana hospitals as well as with insurance companies. The Indiana University Hospitals were at risk of being excluded from these networks because IU's educational and research obligations made theirs the most costly health care in the current system.

Following many months of careful study, consultation and negotiating, the directors of the Methodist Hospital Group and the trustees of Indiana University affirmed the compatibility of their missions, geographic proximity and the unique capability to offer a full continuum of services from primary to highly specialized care and announced approval of their agreement in principle. Consolidation of hospital organizations is a complex endeavor requiring the resolution of important issues and details that will be addressed in a six- to 12-month period of analysis called "due diligence." During this period, there will be an opportu-

nity for public comment and a need to obtain any necessary legal, federal and/or state approval.

Gov. Evan Bayh has announced that the state will make a detailed analysis of the proposed consolidation. Bayh is expected to appoint a committee or task force to evaluate all aspects of the consolidation and to recommend to him what action he should take. Implementation of the agreement requires his approval. Methodist and IU have pledged to cooperate fully with representatives of the state in their deliberations.

One of the major questions asked about the consolidation is what affect it will have on the way the IU School of Medicine educates its students. The school is emphatic in its belief that the new not-for-profit organization will assure the essential critical mass of patients and facilities needed in both the inpatient and outpatient settings. Residency training programs will merge and be under the supervision of the dean of the medical school. All of the restructured educational and training programs conducted in the new organization will require the approval of the various appropriate accrediting agencies. The strong and vigorous medical education program in Indianapolis is essential to the success and survival of Indiana's unique statewide medical education system.

Many issues and questions are yet to be addressed and answered. Will the merger reduce staffing needs and eliminate unnecessary redundancies? What will be the new medical staff organization structure and how will clinical privileging issues be



resolved? Will the existence of the new entity enhance educational and research programs while serving the health care needs of the public with efficiency and high quality?

The new organization will have a stunning array of talented individuals and outstanding physical facilities. Annual revenues are expected to be in excess

of one billion dollars.

The momentous decision to join Methodist Hospital, University Hospital and the Riley Hospital into a new private not-for-profit organization will assuredly have a profound impact on medical education and health care in Indiana. The "due diligence" period is an opportunity to examine and to affirm the wisdom of

the agreement. Indiana physicians have a vested interest in the quality of education and patient care. It behooves all physicians to be informed and to participate in the ongoing discussions and evaluation. □

*Dr. Lukemeyer is chairman of the editorial board of Indiana Medicine.*

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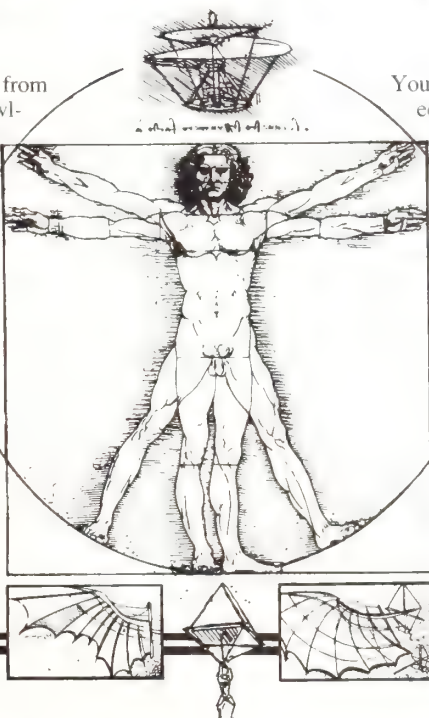
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## On the road to family medicine

Laura Eizember, MS4  
Indiana University School of  
Medicine

**M**y roommates were still asleep when I left that first morning, short white coat in one hand, map and car keys in the other. I can't say that I didn't have second thoughts about my assignment at that moment.

The wisdom passed down to us from prior classes had been that the best part of the new decentralized family practice rotation was the chance to "get away" from the medical center. Having enjoyed the first three months of junior year at the medical center, I wasn't exactly sure what that meant, but I had decided to take the advice to heart.

So not only had I chosen a site away from Indianapolis to spend the month of September, but I also had asked to be placed with a physician in a rural practice. In retrospect, I'm not sure what my suburban frame of reference had expected, but the 45-minute drive to the office that lay ahead did seem a bit daunting. I bundled into my car for the first of many trips, but any regrets I had were decidedly short-lived.

Three quarters of an hour later, a small green sign with white letters spelling "ARGOS" directed me off the highway onto a two-lane road. After passing several farmhouses, an old drive-in restaurant and a church, my destination came into view: a one-story brick, office-in-the-round building with a sign reading "Argos Medical Center."

I again went over the information about my preceptor that had been provided before the rotation: "graduate of the IU

### Clerkship boosts interest in family medicine

T.J. Bahn, MEd  
Indianapolis

**T**he literature on factors that influence a medical student's choice of specialty is clear on one point: of all the possible institutional interventions a medical school can embark upon to increase the numbers of graduates entering family practice residencies, the required third-year family practice clerkship is the most potent.

Four years ago a four-week clerkship was introduced at the Indiana University School of Medicine in year three. The results have corroborated the research, as the percentage of students entering family practice postgraduate training doubled to more than one-fourth of the class between 1992 and 1993. The

obvious difference between those two graduating classes was that the '93 group was the first to have the required family medicine clerkship. The class of 1994 continued the trend, with slightly more than 25% entering family practice residencies.

Printed here is the story of one medical student, Laura Eizember, who will enter her training in July in family practice. Her retrospective on her family medicine clerkship provides some reasons for the profound impact of this clerkship experience on the choice of her medical career. □

*Bahn is director of educational services, Department of Family Medicine, Indiana University School of Medicine.*

School of Medicine, does obstetrics, two partners." By the end of the month, I could have added pages to that description. I would have described the early morning rounds at the local hospital half an hour away and the traveling time filled with discussions about the changes occurring in health care. Also included could have been the interactions among the three physicians in the office, each with their own style and their own practice: one established, one building a new practice and one balancing family and patient care. I also would have included the nurses, whose experience and

perspectives provided instruction in a way that is all too often lost during an inpatient rotation. All of these interactions were instructive and novel in the midst of third-year rotations that were primarily hospital-based and depersonalized.

Depersonalization was not a possibility at the Argos Medical Center. As I entered the waiting area of the clinic that first day, I was met by a sign proclaiming that I was "Our Visiting Medical Student" for the month. The sign also asked patients for their support of the program, and support it they did. Most patients

welcomed the new addition to the office. Many enthusiastically asked, "So, are you going into family practice? Are you going to set up practice here?" Although true continuity of care remained elusive except in a few instances during those four short weeks, I had the opportunity to observe the relationships between my preceptor and his patients. Many of them spoke of the relationship in no uncertain terms, declaring that they had a wonderful doctor and that more like him are needed.

One patient made a particular impression. I clearly remember his reluctance to travel to a larger city for consultation. Assuming at first that the travel arrangements and time were the primary concern, I tried to offer suggestions to simplify the process. With continued conversation, however, it became clear that his reluctance stemmed not from distance or inconvenience, but from the uncomfortable anonymity of the large medical center and the subspecialist's office. He was finally persuaded to obtain the consultation, but it was apparent that the environment to which he was going could not provide the doctor-patient relationship he had with the family practitioner, the

true source of his health care.

Of course, these patients who welcomed me into their office also taught me a great deal about medicine in a more traditional sense. From well-baby checks to geriatric patients, I was treated to the whole range of patients cared for by family physicians. I attended my first delivery that month, and then participated in discussions with a family caring for their terminally ill father. Industrial medicine was represented by workers from the two local factories, with minor lacerations requiring suturing or with back and joint injuries needing evaluation.

I spent one morning talking with a class in the elementary school about being a doctor and devoted one afternoon to junior high sports physicals. The enthusiasm of those with whom I worked was contagious and was echoed in the didactic sessions spent at the sponsoring hospital. The days were filled with enjoyable learning about the human condition, as well as about diseases and treatments and usually ended with an amazed realization that the time had passed so quickly and that I would have to hurry to complete at least part of my return journey

in daylight.

During the course of the month, the meaning of the advice I had been given about "getting away" from the medical center became apparent. It didn't simply refer to physical distance, but to a different environment for learning and for patient care. Although being in a small community contributed to my experience, I am now convinced that it is family practice itself that creates an environment conducive to relationships with patients that are themselves therapeutic, an environment that teaches fundamental principles of medicine that often get overlooked by subspecialties.

As I look forward to beginning a family medicine residency this July, I hope I will have the opportunity in the future to open my practice to a medical student and share the enthusiasm for the specialty that the family practice rotation gave to me. I now know I would drive any distance to do so. □

*Ms. Eizember spent her family practice clerkship with John Haste, M.D., and her didactic days in South Bend with Tom Sutula, M.D., and the other residency faculty at Memorial Hospital Family Practice Residency.*



# State asks doctors

Bob Carlson  
Indianapolis

**"G**et the Lead Out!" reads the button on Dave Ellsworth's lapel. In a nutshell, that's what the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) is all about, getting the lead out of lead-poisoned Indiana children and preventing further exposure to lead in their environment.

According to ICLPPP Director Ellsworth, 42,000 Indiana children up to 6 years of age were screened last year through the efforts of local health department nurses and environmental sanitarians, ICLPPP regional lead consultants, physicians and other providers. Ellsworth wants to involve more Indiana physicians in ICLPPP to increase the number of screenings. If you see children in your practice and you're not already in the program, chances are an ICLPPP lead consultant will be calling on you to sign you up.

Currently, participating in ICLPPP doesn't cost physicians or patients a dime in out-of-pocket expenses. ICLPPP provides screening supplies, instruction by a lead consultant, non-medical case management services, even postage-paid envelopes to ship the blood samples to the lab. Ellsworth says that by the end of the year, he'll also have participating physicians, state testing labs and possibly 27 local health departments networked by computer with a central state lead registry.

Lead poisoning is a neurological disease. Ingesting lead paint chips or breathing lead paint dust are the main causes of lead poisoning. Symptoms include developmental delays, learning problems, hyperactivity, deafness and gross motor impairment. In severe cases, the result can be

coma and death. Sometimes there are no apparent symptoms. Only a blood test can reveal the presence of lead in the body. Unfortunately, the effects of lead poisoning are irreversible, but chelation can remove the lead and prevent further damage.

Compared to other states, Indiana is in the middle of the pack in the percentage of cases of lead poisoning, with 10.9% of children screened showing lead levels at or above the Centers for Disease Control and Prevention (CDC) definition of lead poisoning.

Nationwide, \$29 million is spent on childhood lead poisoning prevention programs. ICLPPP's 1995 budget is \$1,200,000. The CDC contributes \$737,000, and \$229,000 comes from federal Title V Maternal and Child Health funds, with the balance coming from Medicaid reimbursements for state-sponsored lab analysis of blood samples.

Ellsworth received his postgraduate degree in health and safety education from Arizona State University. He taught secondary health education with the Scottsdale (Ariz.) Public School System, was director of health education with the Clark County Health District in Las Vegas and was health education coordinator with Northern Arizona University in Flagstaff before coming to Indiana. He was a health education consultant in Maternal and Child Health Services and field director of Project ASSIST (American Stop Smoking Intervention Study) in the Indiana State Department of Health before becoming director of ICLPPP in November 1992.

In this conversation with



# to help test for lead

*Indiana Medicine*, Ellsworth talks about the goals of ICLPPP, how it works and why it is unique among state lead programs in the United States. He also explains how ICLPPP can help Medicaid and other managed care providers and how easy it is for Indiana physicians to participate.

**Indiana Medicine: What is the Indiana Childhood Lead Poisoning Prevention Program?**

**Ellsworth:** The Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) is a regionalized statewide program dedicated to the screening and follow-up of children zero to 6 years of age for the number one environmental health problem of children, which is childhood lead poisoning. From 1982, back when the block grants were developed, until 1991, when the Centers for Disease Control and Prevention (CDC) started awarding categorical grant funds to states, Indiana had a modest childhood lead screening program that worked through the federal Title V Well Child Clinics throughout the state. They screened approximately 86,000 kids over that 10-year period. In comparison, we screened 42,000 last year so obviously the program's grown considerably.

**Indiana Medicine: Why was ICLPPP established?**

**Ellsworth:** In this country, lead poisoning is the number one environmental health problem for children. The Agency for Toxic Substances and Disease Registry (ATSDR), which is a branch of the CDC, estimated in 1984 that 17% of all preschool children in this

country had blood lead levels that exceeded 15 mcg. That's why we have this program, to screen, identify and follow-up on those children who have lead poisoning in the state of Indiana.

**Indiana Medicine: Who runs the Indiana Childhood Lead Poisoning Prevention Program?**

“  
*The number one goal of this program is to have access to services in all of our counties.*  
”

**Ellsworth:** Our lead program is part of Maternal and Child Services in the Indiana State Department of Health. The program addresses the needs of 485,000 children. We interact with and rely a great deal upon the services of our providers that we sign up, but I give most of the credit for the success of this program to the local health department health officers, county health nurses and environmental specialists. Without their help and their involvement in this program, it would not be able to function.

For the logistics of running the program, the state is divided into seven regions. Each region has two field-based program consultants who report to me. One of these people deals with case management, interacting with the children, the parents, the nurses

and the physicians to see that the medical needs of that child are taken care of. The other team member is a consultant who interacts with the county environmental specialists to do the environmental investigation, to find out where these kids are getting into the lead. There's a tremendous amount of cooperation and networking between our staff and private physicians, county health nurses and the parents from the time you screen the child until the time the child is entered into case management. It can even go as far as community groups finding some paint so the family can repaint their house. Because remember, the number one cause of childhood lead poisoning is peeling and chipping paint. Lead was not removed from paint until 1978, so it has been estimated that over half the homes in America still have lead paint on them.

**Indiana Medicine: What are the goals of ICLPPP?**

**Ellsworth:** We have six main goals in this program. The first one is universal screening. When I took this program over in November of 1992, you could not get a child screened for lead in half the counties in this state, 46 counties. In half the counties, it didn't matter if you got the parents excited about the issue and they realized how important it was because there was no place to go to get your child screened. I'm happy to say that now you can get your child screened for lead in 91 of the 92 counties in this state. We have over 450 providers with more signing up on a daily basis. The number one goal of this program is to have access to services in all of



our counties.

This is predominantly an issue of urban, older homes, but I can show you instances of wealthy farmers who live in pre-1900 homes that have a lead-poisoned child due very often to improper remodeling techniques of a leaded environment. By the same token, very old communities along the Ohio River also have many homes laden with lead.

By knocking on physicians' doors, knocking on health department doors, literally going in and selling this program the same as they market drugs and band-aids, we've said to these physicians, will you do lead screening for your kids that come into your office if we make it as easy as we possibly can? And that's been successful. We screened about 86,000 kids from 1982 to 1991. In 1991, we applied for and received a five-year renewable grant in addition to what we had already been receiving, to expand this program, to add staff and the salaries required, to provide universal screening and free supplies.

The second goal is appropriate medical case management with private providers and local health department nurses. It does absolutely no good to stick a bunch of kids' fingers for lead if you're not going to do anything with them. CDC didn't fund the 31 original

states to build up large screening programs. Their first question is, what did you do with them after you screened them and found lead? In Indiana, we're finding 10.9% of the children whose fingers we stick at or above the levels which are defined as childhood lead poisoning. Five percent of the children we stick are at or above 15 mcg/dL (micrograms per deciliter), and 3.2% are at the action level of 20 mcg/dL. That's three out of every 100 kids we screen. We're screening 42,000 children annually, which multiplies out to about 1,250 current cases of childhood lead poisoning. If you were to screen the 485,000 children in Indiana who are from zero to 6 years old, you'd be looking at about 15,000 cases of childhood lead poisoning.

So lead is out there, we're finding it, and that is why, in a statewide program such as ours, you've got to have a balanced program. You can't just do screening. So our second, third, fourth and fifth goals of this program are to give balance to this program, which is what CDC wants. That means we've got to provide environmental management and we have to have that interaction to find those kids [whose blood tests show lead levels] of 20 mcg/dL and above.

Our third goal is to have timely environmental investiga-



tions by the local environmental health specialists. My staff takes the county nurse or the environmental scientist from the county with them so it becomes a "train the trainer" concept. If we can train these county employees, give them the equipment and the knowledge and let them know that we're going to be there, almost holding their hand, to do this work, then they'll do it for years, even if federal funding becomes limited.

The CDC is very, very satisfied with our program and has recently funded the purchase of 20 XRF (x-ray fluorescent) paint analyzer instruments, in addition to the 10 we already have. Instead of peeling paint chips and sending them to the lab and waiting two weeks for them to grind it up and run it through the analyzer, they put the XRF instrument up against the wall, pull the trigger, and it reflects a radioactive beam through the paint, up to 30 layers, and gives the county environmental specialists an exact digital readout, on the spot, whether that paint has lead in it and to what

### For more information

Physicians who wish to participate in the Indiana Childhood Lead Poisoning Prevention Program may call the Indiana State Department of Health, (317) 383-6662, fax a request to (317) 383-6757 or write to ISDH, Maternal and Child Health Services, 2 N. Meridian St., Indianapolis, IN 46204. □



degree. That's timely environmental investigation.

If you have a child with a lead level of 40 or 45, the doctor and the medical community have got to know what's going on in this child's home as soon as possible. In fact, under the protocols of some medications physicians have to use for chelating, you can't release a child from the hospital until his environment has been investigated for lead.

Our fourth goal is data management and case control. When you're screening 42,000 kids, you've got to manage their cases and you've got to make the physician aware of what's happened with their patients. Has the nurse been out there? Have the parents been talked to? That's probably the number one goal that we're going to stress this year. We've got all the infrastructure in place for screening the children and bringing up a provider network. Now we've got to focus on data management, getting the computer systems lined up.

Educational intervention is our fifth goal. Our case managers have a charge to give talks in their regions to the Kiwanis, to mothers'

groups, to anyone that wants to hear about childhood lead poisoning. Both members of the team are involved in developing regional lead poisoning advisory councils made up of people who live in their region. Eventually from those seven groups, individuals will be pulled to form a statewide lead advisory council.

Laboratory capacity is our sixth goal. We've met that goal

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*Because of Indiana's transition into managed care, I think the number of children that are going to be screened is going to go up.*

with this program. When I took the program over in November of 1992, I wanted to make lead screening a McDonald's concept, one on every corner, so to speak, so any parent could go into any doctor's office that sees children, any clinic, or any health department to get their child screened. But to do that, you have to have someplace to send all that blood.

We realized that if we were going to start a program of this size and have 40,000 samples of blood coming in per year, we had better have some lab capacity somewhere to analyze this blood. So we contracted with local health department labs that could test large quantities of blood coming in on a daily basis. We provided an

additional lab instrument to analyze that blood and funded the staff necessary to run a lead lab.

The lead labs are located in the Indiana State Department of Health building and in the Lake County, Vanderburgh County and Marion County health departments. They're all CLIA-approved, and they're all staffed with highly professional people. State and federal Medicaid reimbursement for children pays for those laboratory analyses. If we sent all of these samples out of state, the receiving private reference laboratory would get all that money. Instead, we support our labs, and any excess funds support the program's other needs. This is unique in the United States. Most lead programs do not sponsor the laboratories and certainly do not see the reimbursements from the laboratory analyses.

”  
**Indiana Medicine: What are the lead screening requirements for the physicians in Indiana?**

**Ellsworth:** There is no law that says a physician in this state must screen a child for lead poisoning. However, if a child is a Medicaid patient and if the physician is an HMO or PCCM (Primary Care Case Management) Medicaid provider, then because of Medicaid law and rules, that physician is required to screen for lead through the EPSDT (Early Periodic Screening, Diagnosis, and Treatment) Program. Because of Indiana's transition into managed care, I think the number of children that are going to be screened is going to go up.

The lead staff is already knocking on these physicians' doors because when they become



either a [Medicaid] HMO or PMP (Primary Medical Provider) provider and they're told that all of the Medicaid-enrolled children who come through their office need a lead screening, they're going to say where do I go, who do I get to do it, where is it most cost effective? All of a sudden, they need us. If you're a pediatrician or a family doctor who sees kids but you're not a Medicaid provider, you don't have to screen those kids for lead. Good medicine says you should, but legally you don't have to.

**Indiana Medicine: What is the compliance rate at this time?**

**Ellsworth:** All Medicaid children are required to have an EPSDT examination, and a blood test is part of that. I can't tell you how many of the physicians that are Medicaid providers are following the EPSDT standards. I think this managed care situation is going to solve some of this because the responsibility for screening for lead is part of the Medicaid managed care contract, which is binding. So the compliance rate could go up.

**Indiana Medicine: ICLPPP is set up to help physicians with lead screening. What exactly can a physician expect?**

**Ellsworth:** We literally knock on their door, carry in their supplies and show physicians how they can screen their patients at no cost to the patient and no cost to physician. I never promise a physician that it's going to be free forever. As long as we have CDC funding, MCH (Maternal and Child Health) funding and Medicaid reimburse-

ment and we can pay the bills of these laboratories and buy these supplies, it's free. We sign them up and give them a provider number, which gets them into our computer so that we can track them and provide them with reports on their children.

The supplies include items such as very brief, very basic, very cost effective brochures about childhood lead poisoning. We also leave them with a starter packet of testing materials and show them how to use everything. We buy state of the art capillary collection tubes from a company in Germany. We give them the alcohol prep pads to clean the fingers, a little band-aid, the microtainer lancet and sterile sponges to wipe off the alcohol. Everything is packaged 100 to a bag, and we give the physician as many bags as necessary. Our case management people teach the doctor's office staff exactly how we want the labels for the blood tubes and the transmittal form filled out. Once a week, they put the box [of blood tubes] into a pre-addressed, postage-paid biohazard envelope and mail it to our regional laboratory. So all they have to do is stick the finger of the kid, get enough blood in the tube, pull off the strip, seal it, fill out the form and set the envelope out for the local mail carrier. Between three and five days later they get the results back from the laboratory.

When they run out of any items, they fax us an order form. We fill orders on a daily basis. We try to make it as user friendly on the physician as we can. If they don't do any blood work in their office, we have community labs as providers.

Physicians are going to read

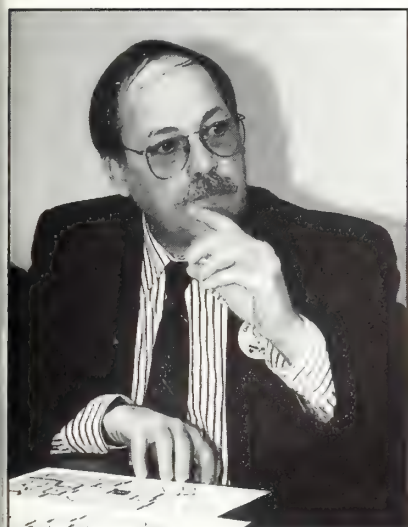
this article and say "they've got this thing thought out well, but I don't see who is responsible for the case management. If I screen these kids for lead, am I going to be held responsible for going out to that kid's house and finding out where the lead is?" The answer is no. When a physician joins our program, they also receive the support of the county health department and the state lead staff to do the environmental [work] and the parent contact and the non-medical case management. Physicians know that you don't screen a kid and then just forget it. That's why they should participate with us. Our state staff in collaboration with the county health department takes care of the follow-up.

**Indiana Medicine: Is the physician kept informed of the environmental investigation and the non-medical case management?**

**Ellsworth:** If the child has a private physician overseeing their medical care, our staff interacts with the physician of record for those children. With managed care, that's going to be a lot easier because they are going to have physicians assigned to them. Generally speaking, in the real world, it's the county health nurse who sees the child's physician because they interact with those physicians on a daily basis. They know which physician in their county sees these kids. But my staff makes sure that all this networking and collaboration happens and that the doctors aren't left out of the loop.

**Indiana Medicine: Who keeps track of when it's time for re-**





testing?

**Ellsworth:** The program that we use to manage all these kids and keep track of all this data is called STELLAR, which stands for Systematic Tracking of Elevated Lead Levels and Recording System. This program has a feature that we haven't started using yet. At the end of each day, you can batch all those kids' files, and it will generate nine different letters that can be mailed to parents, to providers, to the county, anybody that you want to mail it to based on the level [of lead in that child's blood sample]. For example, a letter to parents might say something like "Your child is found not to have lead poisoning. Please see that he gets an annual test one year from the date above." The computer does all that automatically. One other thing STELLAR does is produce reports by provider. I can give a particular doctor a report on all of his open cases, when they were screened last, when they need their next screen, etc. We've started sending our providers

some of those, but I've just recently gotten more staff to help us with that.

**Indiana Medicine: Do you send out a hard copy?**

**Ellsworth:** Right now, any reports we send out are hard copy. But I've just been approved by the Centers for Disease Control for about \$100,000 to network this lead program throughout the state. The field staff and the lab sites will all be linked up with the state lead registry. But the most exciting part of this is that any physician office in Indiana with a PC will eventually be able to dial an 800 number to access this central state lead registry. All this data will also be linked with the Indiana Health Data Center coordinated by the ISDH.

**Indiana Medicine: How can the physicians find out if the patients have already been tested?**

**Ellsworth:** Right now, they can't. Are we duplicating lead screens in some cases? Probably. The only way that physicians now can find out if a patient has been screened for lead would be to call the lab [in their region]. Very time-intensive. But we're working on it. We're almost there. A fully networked state lead registry will be up and running by the end of this year.

Of course, confidentiality of medical information will be protected under this data collection system.

If Congress is going to continue to fund the lead program nationwide, we have to show numbers. The lead program for the United States is \$29 million. We get \$737,000 in Indiana. To

continue to receive that level of funding from Congress, we must show them the results and the effects of all this money going out to the states, and the way to do that is with numbers. They've got to be able to show in hard numbers that these kids are being screened, case managed, followed up and environmentally protected from lead.

**Indiana Medicine: What message would you like to leave with physicians throughout Indiana about ICLPPP?**

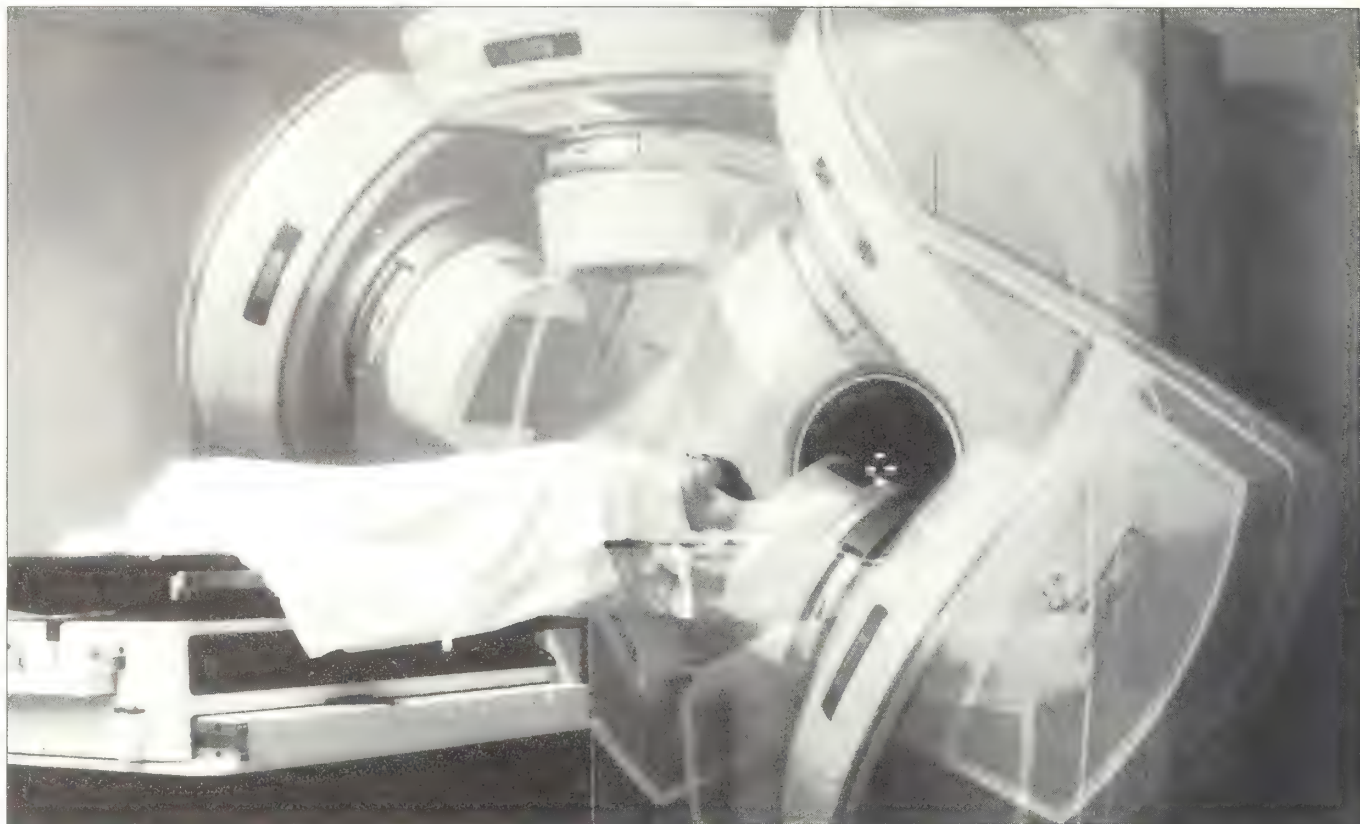
**Ellsworth:** It's available to your patients. It's available to you. I think you should participate in the program so that the children you see have the same opportunities to be screened for lead as the children that are currently in it. A lot of time, energy and dollars on both the federal and state levels has gone into this program. I believe that every parent has the right to know if their child has a medical condition or a disease. All it takes is a simple blood test. They may not have \$10,000 to abate their home of lead, but they can at least take advantage of the program through their physicians and know if their child is lead poisoned. □

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*Bob Carlson is a health care writer based in Indianapolis.*



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# Domestic violence: A health concern

Mary M. Von Burg, M.S.  
Roberta A. Hibbard, M.D.  
Indianapolis

Family violence is not just a criminal concern. It is a public health problem. Domestic violence against women may be the single most common etiology for injuries in women presenting to the health care system, accounting for more injuries than automobile accidents, muggings and rape combined.<sup>1</sup> An estimated 4 million women are battered each year by husbands, boyfriends, girlfriends or significant others.

Women who are single, separated or divorced (or are planning a separation or divorce), between the ages of 17 and 28 years, who abuse alcohol or other drugs or whose partners do, who are pregnant, or those whose partners are excessively jealous or possessive appear to be at higher risk for domestic violence.<sup>2</sup> Women who are homeless often

## Abstract

Domestic violence may be the single most common etiology for injuries in women presenting to the health care system. There is a national effort to begin to ask all female patients about family violence. Physicians have a responsibility to identify, educate and appropriately manage and/or refer patients in violent relationships.

Table 1	
Most frequent indicators of possible battering	
Physical injuries	
A. Most common types	
1. Bruises	
2. Lacerations, contusions	
3. Fractures	
4. Bite marks	
5. Rape/sodomy	
6. Burns	
B. Most common locations	
1. Head and neck (bruises, laceration, strangulation)	
2. Upper extremities	
3. Chest	
4. Lower extremities	
Common complaints/observations	
1. Suicidal ideation	
2. Seizures	
3. Chronic pain	
a. with normal exam associated with old injuries	
b. associated with old injuries	
4. Sleep disorders	
5. Delay in seeking care	
a. untreated old injuries	
b. injuries in various stages of healing	
c. victim's concern about injury inconsistent with severity	

present as battered women. They are sometimes homeless because they left a battering situation.

The rate of violence committed by intimates is nearly 10 times greater for women than for men. Men are more likely to be victimized by acquaintances or strangers. If women remain with the battering partner, the violence usually escalates, and the children are at risk. Fifty-four percent of families

in which women have been battered have children who have been physically abused.<sup>3</sup> Victims are usually referred to as "she" and the batterer as "he," even though battering can include male-to-male and female-to-female battering. Men also present as a result of abuse by either a male or female partner. With lesbian and gay battering, identifying the batterer and victim by gender is

not possible.

In some families, hitting to resolve conflicts is taken for granted; therefore, some women may not initially recognize themselves as "battered."

Cultural differences may affect the manner in which the woman describes her family history, her status in the family, the level of maltreatment that she tolerates or accepts as normal, her perception of herself as a victim and her ability or inability to change her situation or may even affect her ability to tell her story. Some cultures are reluctant to reveal family problems to outsiders.

Patients may be hesitant to discuss the battering and may be reluctant to report abuse due to fear of violence or feelings of shame or self-blame or because of the lack of support from family and friends.

The women may also be concerned for the safety of their children at home and may choose not to disclose abuse at this time. If the woman discloses child abuse, it must be reported to Child Protective Services. If the woman does not disclose child abuse and denies being battered, but you think the children are not safe in their home, you must report to Child Protective Services.

### Identifying victims

The physician should approach the patient in an open and sensitive manner. All staff should be trained to recognize cultural differences and adapt accordingly in the assessment process.

Even though the patient may not choose to acknowledge abuse, each encounter with health care professionals can reinforce the

belief that abuse is not acceptable and that resources are available to assist the patient when she or he is ready to seek help.

Battering may result in a variety of injuries or effects (*Table 1*). Physical injuries include

lacerations, bruises, contusions, burns and fractures, particularly of the head, neck and upper extremities. Pregnancy is a particularly vulnerable time for many women. Vague complaints, chronic pain, old injuries and delays in seeking

*Table 2*

### Clinical signs of possible battering

#### In women:

- Change in appointment pattern, e.g., increased or frequently missed appointments.
- Vague or non-specific physical or psychological complaints (i.e., fatigue, anxiety, depression, "nerves," fearfulness, sleeplessness, ragefulness, loss of appetite and dissociation).
- Extent or type of injury inconsistent with patient's explanation.
- Repeated use of emergency department services and/or physician shopping.
- Problems during pregnancy, specifically, pre-term abortion, bleeding, intrauterine growth retardation, hyperemesis, and any other injuries.
- Self induced abortions or multiple therapeutic abortions or miscarriages.
- Eating disorders.
- Self-directed abuse (i.e. cutting self), depression, attempted suicide.
- Severe anxiety, insomnia, violent nightmares.
- Alcohol or drug abuse.
- Complaints of jealous, possessive male partner.
- Frightened of partner's behavior.
- Hit, slapped, kicked, shoved, or had objects thrown at her by partner.
- Abused as a child or seen mother abused.
- Single car crashes (victim may also be passenger).
- Emotional abuse or marital discord observed by staff.

#### In partner:

- Explosive temper.
- Criticizing and denigrating partner, frequent "put downs."
- Controlling of partner, attempts to control health care setting environment (may arrive unexpectedly).
- Breaks, throws objects when angry.
- Makes all decisions on money and family.
- Overprotective.
- Jealous, suspicious.
- Has hit, slapped, pushed partner.
- Alcohol or drug abuse.
- Witnessed abuse as a child or was abused as a child.
- Defensive about relationship with partner.



Table 3

**Suggested questions for suspected victim\***

1. Have you ever experienced a relationship in which you were hit, punched, kicked or hurt in any way? Are you in such a relationship now?
2. Do you know where you could go or who could help you if you were abused or worried about abuse?
  - If no, you should think about a "safe place" where you could go, someplace within walking distance, if at all possible, where you could spend the night. Do you know of such a place? Let's write it down. If not a close place, make an effort to keep your car keys with you at all times or hide an extra set or leave with a friend so you can get away. Make arrangements with a friend or relative where you could go to spend some time away from your significant other while he/she "cools down." Can you think of such a place? Let's write that down.
  - Community resources should be given to the woman at this point.
3. Does your partner use drugs or alcohol?
4. How does your partner act when drinking or on drugs?
5. Is your partner verbally abusive?
6. Is your partner physically abusive?
7. Do you use drugs or alcohol?
8. How do you act when you have been drinking or on drugs?
9. Are you verbally abusive?
10. Are you physically abusive?
11. Does your partner lose his/her temper with you?
12. Does your partner lose his/her temper with the children?
13. Has there been any time during your relationship when you and your partner have physically fought?
14. Has your current partner thrown things at you?
15. Does your partner threaten you with abuse?
16. Has your partner hit, slapped, shoved, grabbed, kicked or otherwise physically hurt you or any member of your household?
17. If you've been abused, remembering the last time your partner hurt you, mark the places on the body map where he/she hit you.
18. I notice you have a number of bruises. Could you tell me how they happened? Did someone hit you?
19. You seem to have some special concern about your partner. Can you tell me more? Are you fearful?
20. Have you ever received medical treatment for any abuse injuries?
21. Many patients tell me they had an argument with a partner and later state that they were beaten. Could this be happening to you? Are you being beaten?
22. (If applicable) If yes, has your partner hit you since you've been pregnant?
23. If yes, did the abuse increase since you've been pregnant?

\*It is not intended that each question be asked. Only one or two questions are necessary.

care are commonly observed in battered women.

Many women never seek medical assistance after they have been battered. Research shows that nontrauma treatment sites are the major source of medical care for abused women.<sup>4</sup> Those who do present for treatment of injuries and bruises often report they were received in a fall, an accident or a bump into a door.

Clinical clues to possible battering may be present in the pattern of behaviors, symptoms or partner characteristics as described in Table 2. Victims of deliberate physical assault, like victims of automobile accidents and falls, often suffer injuries at multiple sites. However, violent men tend to hit in the same way during violent episodes; therefore, women may have clusters of injuries in various stages of healing all in the same area of the body. One in five battered women presenting to physicians have sought medical attention for injuries from abuse 11 times previously.

**Approaching the patient**

Do not search for abuse in women who present for care, but be familiar with battered women syndrome, recognize clues and understand the stress involved. Exploring, nonjudgmental questions broached in a caring, concerned manner with active listening are best. Attempting to force your opinions or suggested plans rarely works. Some suggested questions to adapt to your style of interviewing are listed in Table 3.

If, because of time pressures, you know you cannot do a good job of listening, do not invite the patient to tell her story. Validate the patient's experience, tell her

you are concerned and have identified the name and phone number of resources with staff who are trained to help in these situations. Communities are encouraged to develop lists of local resources available. The Indiana Coalition Against Domestic Violence (1-800-332-7385) can assist with this. Even if you are unable to listen to a patient's story, it is still important to ask basic screening questions regarding domestic violence.

Avoid using terms such as abused, battered or domestic violence. Many victims may not relate their situation to these terms.

The physician must recognize that the emergency of the abused woman is frequently not evident in laboratory tests, x-rays or physical examinations. For example, of a group of 36 women who went to the emergency department alleging drug overdose, but having ingested pharmacologically insignificant amounts of material (several aspirins, two Darvon, etc.), 22% had histories of domestic assault. In these cases, the abused woman can be recognized if the practitioner accepts the legitimacy of an "emergency" without anatomic or physiologic pathology.<sup>4</sup>

The battered woman is often accompanied by a male partner who wishes to be with her whenever she is being seen and questioned by anyone, including the physician. The physician may have to ask the police department to contain the partner.

Interview the woman alone, in a place that affords privacy so the patient can speak frankly. Interview family members if appropriate. If the woman is

*Table 4*

**Safety plan\***

Arrange a safety signal to alert a neighbor to call police.

Have bag packed and include the following if possible:

- Change of clothes for yourself and children
- Address book that includes phone numbers of friends, relatives, doctors and lawyers.
- Money, including change for pay phone.
- Extra keys to house and car
- Emergency medicines
- Important papers, including checking and savings account numbers; copy of lease; copy of No Violent Contact Order/Protective Order; birth certificates; Social Security numbers for yourself, children and partner; and ADC/SSI/Medicaid cards.

Special tips to remember:

- Avoid long distance calls if possible because long distance numbers can be traced.
- Advise the school system, the courts and the welfare office not to give out any information.

\* This safety plan is printed on one side of a laminated referral/resource card that lists helpful information for abuse victims in Marion County and surrounding counties. The card is designed to be small enough for a woman to conceal on her body. For information on obtaining the cards or for assistance with developing such a card for your area, call (317) 630-6307.

accompanied by another woman, the other woman may be her partner and precautions should be taken.

For some women, answering "sometimes" to abuse questions is easier than yes or no. There is a nationwide effort to begin asking abuse questions of all female<sup>2</sup> patients because of increased family violence awareness in the community and media. The patient needs to understand that her situation is potentially lethal. Remind her that battering is a crime. Ask her what help she

would like. Availability of resources and thoughts for a safety plan are crucial. Some communities provide business card size laminated cards with resource phone numbers on one side and a safety plan on the other. Resource phone numbers might include law enforcement agencies, crisis intervention workers, emergency victim assistance groups, shelters, support groups, help lines and the prosecutor's office. A safety plan (Table 4) would include a safety signal and a packed bag with key survival information and materials.

### Documentation

Documentation is very important for several reasons: 1) it is a record of the good care given to the victim; 2) it ensures good follow-up care; 3) it helps the battered woman legally if she later becomes involved in custody disputes or prosecution. Medical record documentation should include a full description of the injuries (type of injury, size and location on the body), the patient's answers to the questions about domestic violence and the referrals that were made. If you suspect battering, state how you think the patient was battered and what you did about it. If a camera is available, take pictures. If a camera is not available, use a body map (gingerbread woman if necessary) to show locations of various injuries and bruises.

### Conclusion

As public awareness of domestic violence increases with media coverage of actual cases, more battered women probably will be presenting to physicians for help. Physicians must be prepared. Awareness of the problem and education is not enough. Physicians must begin to accept the fact that domestic violence does occur and can occur in any family regardless of socioeconomic level, race or ethnic or religious background.

When a patient says she has been abused, take time to listen to her story, without judging or minimizing. This may be the first time she has told it, particularly to a helping professional. Believe what she tells you. Ask if this has happened before, how often and to what extent, just as you would ask about previous episodes of other medical conditions. Batterers and victims alike may be doctors, lawyers, teachers, prominent business and community leaders, judges, as well as white collar workers or laborers. Physicians can play a key role in identifying and treating battered women and getting them on the road to recovery. □

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### ISMA offers referral service

As a service to members of the Indiana State Medical Association and other health care providers, the ISMA, in cooperation with the Indiana Victim Assistance Network, is offering a new referral service that provides local telephone numbers of agencies that can help victims of family violence.

For local information or educational materials on family violence assistance in your county, call Janice Herring at the ISMA, (317) 261-2060 or 1-800-257-4762. □

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# Physician-assisted suicide and euthanasia: A house staff debate

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Although many strides have been made in the treatment of advanced cancer, unfortunately, approximately half of the patients who are diagnosed with cancer are destined to die from it. The internal medicine residency rotation at Indiana University affords the opportunity for our house staff to see many patients with curable neoplasms such as germ cell malignancies and lymphomas, but the rotation also reminds the house staff of the limitations of medical therapy in many other patients. A tertiary hospital active in clinical and basic research often draws patients seeking an aggressive, "no holds barred" approach, yet it is inevitable that all patients (some sooner than others) eventually die. Quite appropriately, medical training emphasizes pathophysiology of disease with therapeutic interventions for acute and chronic illnesses. Even minor success or brief remissions provide a physician and patients with immediate gratification with secondary gain from family and colleagues.

Care of the terminally ill is less fulfilling to the problem solving oriented physician. The current educational process often sends conflicting messages by treating patients with incurable malignancies. Systemic chemotherapy or focal radiotherapy can be the principal palliative measure in selected patients with advanced

cancer. When the therapeutic options are exhausted, the physician and patient must focus once more upon issues of supportive care.

A few months ago, I had the rare opportunity of having an extraordinary house staff, who not only sought answers to standard medical questions but did not shirk from ethical debates, particularly physician-assisted suicide. The financial costs and emotional toll of the care of the terminally ill have provided a platform for discussion. As a culmination of this rotation, we divided our team into two groups to debate whether physician-assisted suicide should be legalized. While the subsequent discussions may be somewhat simplistic and certainly do not resolve the issue on the table, it serves as an assurance that compassion for patients remains at the core of today's physicians.

This paper summarizes the arguments in opposition to and in support of physician-assisted suicide.

## Opposed

To some extent, we all hate what we do. No, it's not the long hours, the weighty responsibility, the demanding nurses or the irritable patients that I am talking about. Rather, it is the helplessness we feel when we see another human being faced with a life that promises pain, suffering and premature death. We do what we do to give hope to people. We want to decrease pain, extend the length of life and give comfort to them. When we can't do that, we hate what we do.

This is the situation that Dr. Jack Kevorkian [the Michigan physician who has helped several people commit suicide] faced. He saw patients without hope, and he knew that standard medical care could not give them any hope, so he came up with his own solution – he helped them die. Death, after all, is the ultimate relief for the terminally ill patient without hope. Dr. Kevorkian did what most, if not all, of us have thought about, and for doing that he faces murder charges. But in doing so he has raised the question of whether or not it is within the realm of the physician (or health professional) to help the hopeless patient end his own life, and hence to avoid a life that promises only suffering. Isn't it reasonable to save them from their pain? Aren't we then truly acting in their best interests?

First, let's consider the players in this situation: The physician's accepted tasks are to prolong life, to increase function and to reduce suffering. Truly, with the advances in medicine we are able to accomplish both the prolongation of life and the reduction of suffering better than ever before. Still, everyone eventually does die and prolonging life becomes impossible. Then the task changes to the reduction of suffering and preparation of the patient for death.

The patient's task is to simply live as best as he or she can and to use any available physician services that he or she chooses. These choices are based on patients' past experiences, their underlying beliefs and the advice of the physician.



Some may put the family in the equation. This is true when the patient is not competent to decide what care to accept – in which case that decision falls to the family. Although the beliefs and desires of the family are important to most patients, their desires are truly secondary. Hence, the thrust of my discussion will center around the patient, whose beliefs and desires are cardinal.

So what happens when patients ask the physician for help in ending their lives? Nearly all patients are capable of committing suicide by themselves. Many, however, may be too afraid to do it on their own, and thus ask the physician to help them to do it painlessly. We have gladly shouldered the task of prolonging people's lives. Their lives are often in our hands. Isn't it reasonable to take it the next logical step? Wouldn't it put an end to that horrible situation where we powerlessly watch them suffer and die?

There is no doubt that it would help them avoid that suffering, but even so, to allow it would be wrong. It is not only wrong, but it is an open invitation to a deadly net of even more difficult situations. It would not simplify things. Instead it would complicate them more and open up a whole new set of dilemmas.

Here is why:

1. It betrays our roles as physicians. When we become physicians (or other health care providers) we enter into a trust with our patients – a trust that says that we will be their advocate. We will use our skills to prolong their lives and reduce their suffering. They place their trust and their

lives in our hands. When we agree to end those lives, many physicians and patients would believe that we betray that trust and go against all we have stood for.

2. It makes the physician too powerful. Patients listen to us. They accept our decisions and the effect those decisions have on their lives. When choosing to end their own lives, patients rely on their underlying beliefs about life, death and beyond. If we enter that decision not sharing those views, we may influence them to agree with our personal views on life and not their own. We can truly turn them in either direction. That power is too much to mandate to a physician. The judgments a physician makes in this area are simply non-medical and the physician shouldn't be the one making them.

3. We don't know the psychological status of the patient. One of the criteria of pathological depression is the desire to commit suicide. Terminally ill patients are likely to suffer from depression. How would we know whether a patient's desire to commit suicide reflects a rational decision or is simply a manifestation of depression? And if the patients are depressed, do we treat the depression and ask them if they want to commit suicide only when they are not depressed? At this point, the decision of whether or not a patient is "rationally" desiring suicide becomes subjective. The physicians become the judge of this, and their subjective beliefs may dictate whether the patient lives or dies. To most people this is unacceptable.

4. Once we are allowed to do it, we will soon find ourselves

obligated and even expected to help them commit suicide. Once the right to choose death exists, we will be denying someone that right when we don't give them that choice.

5. Who will be the one to determine when a situation is medically hopeless? The patient usually cannot do this because he lacks the medical knowledge. The physician has the medical knowledge, but the decision may be very subjective. What if the physician is misinformed and the situation is not medically hopeless? What if the physician is in an adversarial relationship with the patient? So then will a committee decide? Who then decides who is on the committee?

6. The abuse potential is great. Not all physicians are caring, trustworthy, honorable or concerned only about the patient's needs. What if a family member wanting an inheritance bribes a doctor to convince the patient to commit suicide? Would we be paving a way to allowing outright murder in the disguise of medicine? The potential exists for the legalization.

7. Finally, it leads to even harder problems. What about diseases that are not immediately terminal that involve a great deal of suffering? What happens when the person with cystic fibrosis asks to die? What about children, or the mentally handicapped, or simply the depressed elderly? Once we crack the door, all of the demons will rush out, and a once difficult situation increases tenfold in its difficulty.

Although it seems appealing to allow the terminally ill to end their own lives, to do so would be



a horrible mistake. Clearly it does not make the situation easier. It worsens it.

Life is inherently hard and sometimes death is harder. All people suffer. It is simply part of what we are. To seek out simplistic solutions to avoid this fact is as fanciful as it is wrong. Perhaps instead of doing this we need to come to grips with suffering and even death, both as individuals and as a society. Once we do that, we may still hate that part of our jobs, but perhaps we will cope with it better and in doing so be the most benefit to patients when they need us most.

### Support

While we have gathered here to debate the oppressively complex issues of euthanasia and physician-assisted suicide, I do not envisage my true role as attempting to dissuade you from your position. Similarly, I do not view your role as attempting to gather our collective voice to advocate your philosophy. The purpose, as I perceive it, is to enter into an intercourse that will ultimately deliver us both to a more comprehensive and evolved understanding. This newly realized understanding can then operate as a stronger and better foundation from which to formulate and administer health care. It is our aspiration that through these discourses we will eventually form a bridge of consciousness that will carry us over the obstacles and turbulent waters separating us.

Our position is not one that advocates or even condones solicitation for or coercion to euthanasia or physician-assisted suicide. It is a position that recognizes and celebrates the privilege of self-determination, autonomy

and dignity. We applaud those individuals who through grit and strength of constitution fight for every available breath regardless of their weaknesses and debilitations. We, however, do not agree with those who seek to impose their values, religious or philosophical, and by so doing condemn a terminally ill and pained patient from liberating himself or herself from a joyless life. We believe that these suffering individuals deserve, indeed have a right to, the facilitation that health care providers can offer. This facilitation should not be limited to merely providing supportive care and analgesia; it should extend to physician-assisted suicide and euthanasia. Physicians possess the knowledge and skills that can enable the patient to escape from his or her intractable condition. Liberation from one's inescapable "natural" demise rather than acceptance of the "natural" and prolonged course is a dignified and reasonable approach to an indignity few of us can appreciate without experiencing it.

It is incumbent upon health care providers and especially physicians to be vanguards. We should not deny patients' wishes and society's wishes simply because some are uncomfortable playing God or somehow sterilizing the death process. The populace has spoken and has done so in a strong voice. While voters in Washington and California did not pass their respective legislation in support of physician-assisted suicide, they did reveal that a large minority exists in support of it. This debate is in its infancy and in evolution. As the "taboo" of even discussing these issues dissolves, an even more significant portion of society will advocate physician-

assisted suicide.

By not operating as patient advocates in offering physician-assisted suicide, we condemn all to existence, and in too many cases, this existence is devoid of life, purpose and pursuit of happiness. This paternalistic parochial stance of not wishing to play God by allowing death in effect relegates one to an opposing pole such that you are not prolonging life, but rather condemning someone to an existence in hell.

Offering aid or assistance to a competent individual in his or her attempt to escape their plight via suicide does not necessarily preclude in any way the normal behaviors of dying patients and their loved ones. The progression through the five stages of death, denial, anger, bargaining, depression and acceptance, will certainly be experienced. I see no detour around this process. The pangs of mourning family and friends will still be present; however, the painful experience may be ameliorated to some extent by the knowledge that their loved one did not needlessly and excessively suffer. And the sense of control the patient exercises over his destiny may also provide for an accelerated adjustment and healing.

The debate over these issues may be deontological for an individual, but cannot and should not be so for a society. The spiritual, psychological and intellectual development varies to such an extent among different groups and between each individual within that group that it is unrealistic to restrictive to operate under the suppressive viewpoint as an absolute right or wrong for a population as varied as we are. It is unjust for some to be allowed, and lauded in the attempts, to

impose their will, their absolute right and wrong, on society as a whole. We must be tolerant of people's desire for self determination and autonomy. This tolerance should extend to the degree that one group's actions do not harm others or restrict another's liberties.

The potential of abuse, whether untoward or intentional, would exist. And the logistics of sanctioned physician-assisted suicide approach the complexities of the debate itself. We should

however, not retreat from these formidable obstacles. The Netherlands has surmounted these obstacles, and we could improve on their safeguards and framework. To shirk from this task would deny the importance of our liberties and betray our spirit and ingenuity.

Participating in physician-assisted suicide is not for every physician, just as it is not for every patient. Those that are uncomfortable should not participate, and those that are uncomfortable

should not restrict the privacy and autonomy of those who choose this path.

John Stuart Mills: "Over himself, his own body and mind, the individual is sovereign." □

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# ISMA member runs for AMA vice speaker

The Indiana State Medical Association will have a special interest in two events at the annual meeting of the American Medical Association in June. John A. Knoté, M.D., Lafayette, is a candidate for vice speaker of the AMA House of Delegates, and the Indiana delegation will push for passage of a resolution for tougher licensing laws regarding the sale of tobacco products.

## Vice speaker candidate

Dr. Knoté is endorsed by the Indiana State Medical Association, the Indiana delegation to the American Medical Association, the American College of Radiology and the Radiological Society of North America.

An AMA delegate for the past 10 years, Dr. Knoté has demonstrated his ability as a spokesperson, a reference committee chairperson and a panel moderator. He is serving his second term on the Council on Medical Service, where he has chaired the Subcommittee on Health Care Reform/Finance, and he is a member of the Subcommittee on Managed Care. He is also CMS representative to the Managed Care Forum and has served on the Convention Committee on Rules and Credentials. As a member of the American Institute of Parliamentarians, he understands the protocols and procedures necessary to organize a productive meeting. He also is a director of the Medical Speakers' Association.

Dr. Knoté effectively conducted the 1994 AMA Leadership

Conference Health Care Reform Panel and the Forum for Medical Affairs breakout session at the Interim 1994 AMA House of Delegates meeting. He is a past president of the Organization of State Medical Association Presidents and is currently secretary of the AMA Forum for Medical Affairs.

A trustee of the Indiana State Medical Association for six years, he served as chairman of the board of trustees for two years and is a past president of his state, district and county medical societies. He currently serves on the ISMA Committee on Health System Reform and is a former member and chair of the ISMA Commission on Legislation and the ISMA Future Planning Committee. Dr. Knoté formerly served on the executive committee of the Physicians Insurance Company of Indiana.

A fellow of the American College of Radiology, he is currently a councilor at large. He is a member of the ACR Commission on Government Affairs, the steering committee of the ACR Council and reviewer of the ACR Digest. Dr. Knoté chaired the ACR's Guidelines and Standards of Medical Care Work Group during the 1992 Radiology Summit. In seven years as ACR Councilor, Dr. Knoté has chaired two of the four reference committees on which he has served. He currently represents the ACR as alternate to the JCAHO Professional and Technical Advisory Committees.

Board certified by both the American Board of Radiology and



Dr. Knoté

the American Board of Nuclear Medicine, Dr. Knoté is a member of the Arnett Clinic staff and has practiced diagnostic radiology in Lafayette for 24 years. He served as director of the Purdue University Student Hospital Department of Radiology for 14 years, and is currently director of the Lafayette Home Hospital Department of Radiology.

## Tobacco resolution

The ISMA resolution calls for the AMA to seek and support legislation that would do the following:

- Restrict the display of tobacco products in prominent places.
- Prohibit cigarettes from being distributed in vending machines.
- Toughen penalties for merchants selling tobacco products to minors.
- Institute retailers' cigarette licensure. □



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To provide income to your family in the event of the main wage earner's death, you need an understanding of the characteristics of the three primary types of life insurance: term, whole life and universal life.

Term insurance, also known as temporary insurance, is used to provide for a short-term insurance need. Term is considered temporary since more than 90% of term policies lapse or are canceled before death because the premiums over time become cost prohibitive due to the higher mortality costs. Premiums generally increase on an annual basis, although some policies offer a level premium for a set amount of years, such as five, 10 or 20, before they increase. There are no savings or cash value elements to a term policy. This makes comparing

policies relatively simple since price, guarantees and the company's financial strength are all easily accessible.

Whole life and universal life are considered permanent insurance since they are designed to stay in force throughout one's lifetime. Whole life premiums are typically guaranteed and remain level throughout the life of the insured. There is also a cash or savings element within the policy. Cash values grow on a tax-free basis with increases attributed to favorable investment experience of the insurance company. The owner of the policy may withdraw from cash values or borrow against them at a relatively low interest rate and without taxation. Premiums are generally higher in the early years when compared to a straight term policy. However, due to the build-up of the cash values, whole life policies tend to remain in force when the term premiums have become prohibitively high. Future premiums can be paid from the cash values, thus providing a paid-up policy without affecting your future cash flow.

Universal life differs from whole life due to its higher degree of flexibility. The owner can

change the face amount or the premium, within certain guidelines, to adjust to changes in their own situation. Thus, universal life is a versatile and flexible tool that can accommodate ever-changing financial and family circumstances. Future premiums, depending on interest rates and current cash values, may be increased, decreased or even skipped, without losing the insurance coverage. As with whole life, cash values accumulate and can be accessed on a tax-free basis, making it a viable option for college funding or as a retirement supplement.

Tax reform has left life insurance in an enviable position. Tax-free accumulation and a potential tax-free payout make life insurance a very strong financial tool. Additionally, in most states, cash values and death benefits, depending on the beneficiary designation, are shielded from creditors, thus creating an unattachable asset from malpractice suits. □

*The author welcomes readers' questions. He can be reached at 1-800-262-3863.*



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# Trends in laparoscopic cholecystectomy in Indiana

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Laparoscopic cholecystectomy is a fairly new procedure that was first performed in France in 1987 and introduced in the United States in 1988. Since then, there has been a rapid expansion of this technique. Nationally, about 15,000 surgeons have received training, and nearly 80% of all cholecystectomies are now performed in this manner.

For patients of any age who have a laparoscopic cholecystectomy, the average length of stay is one to two days, much shorter than for the more traditional open cholecystectomy. Very low mortality and complication rates have been reported for patients undergoing laparoscopic cholecystectomy. Moreover, the hospital charges are less for laparoscopic cholecystectomy than open cholecystectomy, and patients have much shorter convalescent periods at home. A recently published National Institutes of Health consensus conference report reviewed the indications for laparoscopic cholecystectomy.<sup>1</sup>

Much of the current literature reports results for patients of all ages, and many of the initial reports are case series that study the use of laparoscopic cholecystectomy in selected populations. More recent literature

## Abstract

Laparoscopic cholecystectomy is a fairly new procedure that is quickly gaining widespread use among surgeons. In Indiana, 45% of cholecystectomies performed on Medicare beneficiaries over the age of 65 were via the laparoscopic approach, resulting in a shorter average length of stay, 5.9 days, compared to 12.3 days for those who underwent the open procedure. Among these Medicare beneficiaries, the complication rate for laparoscopic cholecystectomy was lower than for those who had the open procedure, 11.3% compared with 16.6%. The trend of the use of the laparoscopic approach for cholecystectomy for older patients and the complications arising from this procedure need further evaluation. □

examines the complications of laparoscopic cholecystectomy when used in less selected populations. The most common operative complications noted are common bile duct, bowel and vascular injuries.<sup>2-4</sup> Postoperative complications include the effects of anesthesia, pulmonary and cardiac problems, urinary retention, ileus, wound infection and fever.<sup>3,4</sup> In a review of published case series, Strasborg and colleagues noted that the overall rate of complications was 5.1%; 2.1% were related to the operative procedure, while 3.0% were indirectly related to the procedure.<sup>4</sup>

As part of the current contract between the Health Care Financing Administration (HCFA) and the peer review organizations, the patterns of care delivered to Medicare beneficiaries are exam-

ined. This approach will provide information about the delivery of care to groups of beneficiaries rather than to an individual as does the traditional case review and, ultimately, should lead to improved quality of care for all beneficiaries.<sup>5</sup>

The Indiana Medical Review Organization (IMRO) has chosen to study the patterns of care for cholecystectomies in Indiana. The purpose of this study is to describe the experience of Medicare beneficiaries over the age of 65 who undergo cholecystectomies, including the rate of laparoscopic cholecystectomies, the number and types of complications associated with laparoscopic cholecystectomy and open cholecystectomy and the cost associated with these procedures.

## Method

IMRO is a peer review organization (PRO) under contract with HCFA to perform medical review for Medicare beneficiaries in Indiana. The database used for this study consisted of all the Medicare Part A claims for inpatient and ambulatory services provided to Medicare beneficiaries in Indiana. This database included the information on the hospital discharge abstract form, known as the UB-82, which includes patient demographic information, the source and type of admission, the principal and secondary diagnoses and procedure codes, the length of stay, diagnosis related group (DRG) and charges for the admission. Additional data included characteristics of the hospital providing the service, such as number of acute care beds and number of house staff, and of the physician who performed the procedure, such as the number of years since medical school graduation and the total number of procedures performed on Medicare beneficiaries during the study period.

The study subjects were Indiana residents who were Medicare beneficiaries over age 65 and who were discharged with an ICD-9-CM procedure code of open cholecystectomy (51.22) or laparoscopic cholecystectomy (51.23) between Oct. 1, 1991, and Sept. 30, 1992. All diagnoses were included. Complications were defined as the complications, other than death, included by the Southern Surgeons Club in its analysis of laparoscopic cholecystectomies.<sup>3</sup> These were defined by the presence of one of the appropriate ICD-9 codes among the secondary diagnoses or the discharge record. Specifically, acute posthemorrhagic

anemia (285.1), respiratory complications (997.3), gastrointestinal complications (997.4), emphysema and other pulmonary complications (998.8), cardiac complications (997.1), urinary complications (997.5), postoperative infection (998.5), pyrexia of unknown origin (780.6), hemorrhage/hematoma complications (998.1) and puncture/lacerations (998.2) were defined as complications. Comorbid conditions were defined by the presence of one of the appropriate ICD-9 codes for chronic cancer (141-160.9, 162-172.9, 174-208.91), chronic cardiovascular disease (412-414.9, 426-429.1), chronic pulmonary disease (491-493, 496), chronic liver disease (571-572.8), chronic cerebrovascu-

lar disease (290-290.9, 294-299.9), chronic renal disease (582-583.9, 585-587, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93), and chronic diabetes (250.01, 250.1-250.91) appearing among the secondary diagnoses in the discharge record for the index admission.

## Results

In the 12-month study period, 3,907 cholecystectomies were performed on Medicare beneficiaries over the age of 65; 2,138 (55%) were open procedures, and 1,769 (45%) were laparoscopic. Laparoscopic cholecystectomies were performed on younger patients, more women and fewer patients with the comorbidity of

Table 1

### Characteristics of Indiana Medicare beneficiaries who had open and laparoscopic cholecystectomies between Oct. 1, 1991, and Sept. 30, 1992

Patient Characteristics	Procedure		
	Open n = 2,138	Laparoscopic n = 1,769	p
Female (%)	57.0	65.7	<.001
Age (years)	75.4	73.9	<.001
Elective admissions (%)	30.6	39.1	<.001
Emergency admissions (%)	38.9	33.1	<.001
Cancer comorbidity (%)	7.4	2.2	<.001
Cardiovascular comorbidity (%)	25.5	22.1	<.05
Pulmonary comorbidity (%)	3.4	4.8	<.05
Liver comorbidity (%)	2.9	2.5	ns
Renal comorbidity (%)	0.8	0.5	ns
Diabetes comorbidity (%)	7.8	7.1	ns
Cerebrovascular comorbidity (%)	0.60	0.7	ns
Average number of comorbid conditions	0.48	0.40	<.001
<u>Surgeon Characteristics</u>			
Number of years in practice	27.2	23.2	<.001
Number of cases in 12-month period	13.4	15.5	<.001

Table 2

### Complications experienced by Indiana Medicare patients undergoing laparoscopic and open cholecystectomies

Complications	Procedure			
	Open n = 2,138		Laparoscopic n = 1,769	
	number (%)	rate (%)	number	rate (%)
Postoperative transfusion	76	3.6	28	1.6
Respiratory complications	64	3.0	25	1.4
Gastrointestinal complications	49	2.3	32	1.8
Other procedure	40	1.9	29	1.6
Postoperative infection	28	1.3	13	0.7
Cardiac complication	26	1.2	17	1.0
Puncture/laceration	23	1.1	7	0.4
Urinary complication	22	1.1	20	1.1
Hemorrhage/hematoma	21	1.1	22	1.2
Unexplained fever	11	0.5	11	0.6
Unexplained abdominal pain	5	0.2	11	0.6
Others	45	2.1	24	1.4
<b>Total</b>	<b>410*</b>		<b>239**</b>	

\* occurred in 354 (16.6%) patients

\*\* occurred in 200 (11.3%) patients

chronic cancer. Laparoscopic cholecystectomies were performed by physicians who had graduated from medical school more recently and who had higher annual volume of procedures. The length of stay was significantly shorter for patients undergoing laparoscopic cholecystectomy as compared to open cholecystectomy (5.9 versus 12.3 days,  $p < 0.001$ ), reflected in much lower hospital charges, \$10,065 and \$18,987 respectively. The laparoscopic procedure was associated with a lower unadjusted mortality rate, 0.9%, as compared with an unadjusted mortality rate of 5.4% for patients who underwent open cholecystectomy (Table 1). The age and sex adjusted

mortality rate for laparoscopic cholecystectomy was 0.86%, and for open cholecystectomy was 5.58%.

A total of 239 complications were reported for 200 patients (11.3%) who underwent laparoscopic cholecystectomy compared with 410 complications for 354 patients (16.6%) who underwent open cholecystectomy (Table 2). The open procedure was associated with higher rates of pulmonary and gastrointestinal complications, as well as more cases of anemia. None of these patients died during the hospital stay.

In each of the four quarters of the study period, the number of

cholecystectomies was approximately the same; however, the proportion that were laparoscopic increased from 41% in the first quarter to 46% in the last (Table 3). While there was some variation in the number of patients who suffered complications or who died, the same basic trend held for each quarter – fewer complications and lower mortality rate among patients who underwent the laparoscopic procedure. The average length of stay for the group who underwent the open procedures was nearly double that for the group who underwent laparoscopic cholecystectomies, 12.3 days versus 5.9 days. This relationship also held constant throughout the four quarters.

### Discussion

Laparoscopic cholecystectomy represents a major change in the method of surgery for gallbladder disease. In this group of Medicare beneficiaries, the laparoscopic procedure is associated with a lower complication rate, lower mortality rate, shorter length of stay and lower cost when compared to open cholecystectomies. Patients who underwent the laparoscopic procedure were younger and more frequently women than those who underwent the open procedure. While it is not possible to comment on how sick each patient was at the time of surgery, nor on all the factors that are used by surgeons to choose the most appropriate method for removing the gallbladder, the higher complication rate and higher mortality rate for open cholecystectomies may reflect patients who had more underlying medical problems at the time of surgery and who had a higher risk of death with any surgical proce-



ture.

This study represents a large population-based sample of patients who underwent cholecystectomies in a one-year period, in a variety of locations from tertiary care academic hospitals to smaller acute care facilities located in rural communities in Indiana. The length of stay for this group of patients is longer than has been previously reported;<sup>3,4</sup> however, this study is limited to patients who were at least 65 years old at the time of the procedure. These older patients may require longer hospital stays than younger patients as a result of underlying medical problems.

In addition, the complication rate for the laparoscopic cholecystectomy is 11.3%, much higher than in the review of several case series,<sup>4</sup> and closer to that reported by Nenner,<sup>6</sup> who reviewed cases of patients over age 65, and found 70 nonmorbid complications in 48 of 304 patients who underwent laparoscopic cholecystectomies. There are several potential reasons. Older patients tend to have more medical problems and may be more susceptible to complications from any surgical procedure. The fact that the patients in Indiana averaged 5.9 days in the hospital when the reported national average length of stay for all patients is two days indicates that these older patients require more intensive levels of medical care such as might be necessary for patients who suffer complications from their surgery. The complications associated with the surgical procedure are also related to the technical skill and expertise of the operator. As surgeons become more experienced, the rate of iatrogenic complications may

Table 3					
Trends in open and laparoscopic cholecystectomies during 12 months, Oct. 1, 1991, to Sept. 30, 1992, for Indiana Medicare beneficiaries					
	Quarter				12-month period
	1	2	3	4	
Total Cholecystectomies	963	942	1,014	982	3,907
– Open (%)	59.2	54.4	51.4	54.1	54.7
– Laparoscopic (%)	40.8	45.6	48.6	45.9	45.3
Mortality rate					
– Open (%)	6.3	6.0	5.0	4.1	5.4
– Laparoscopic (%)	1.0	0.7	0.4	1.3	0.9
Complications					
– Open (%)	16.0	17.1	15.9	17.5	16.6
– Laparoscopic (%)	11.5	9.5	12.8	11.3	11.3
Length of Stay					
– Open (days)	12.1	12.6	12.9	11.7	12.3
– Laparoscopic (days)	5.8	5.8	5.8	6.3	5.9

decrease.

Several limitations should be acknowledged. The accuracy of this study is limited by the accuracy and completeness of the coding on the UB-82 billing form submitted for hospital payment. These forms are limited in the number of secondary diagnosis codes that can be submitted; thus comorbid conditions and surgical complications may not be fully represented. In this database we could not identify all patients who underwent both laparoscopic and open procedures. In addition, some complications may not be apparent at the time a patient is discharged from the hospital and would not be submitted with the UB-82 form as a postoperative complication result-

ing from the cholecystectomy.

Lastly, the 12-month time frame for reviewing trends in complication rates, mortality and length of stay may be too short for definite conclusions to be drawn. Further analysis should be done with additional data.

This study reveals that while the rate of laparoscopic procedures is less than reported for younger patients, the laparoscopic procedure is gaining popularity among surgeons and patients. Moreover, patients who have the laparoscopic procedure have fewer complications, less in-hospital mortality and much lower hospital charges and require significantly shorter hospital stays. Nonetheless, patients must be carefully screened

and surgeons appropriately trained for these rates of morbidity and mortality associated with laparoscopic cholecystectomies to continue or decrease. □

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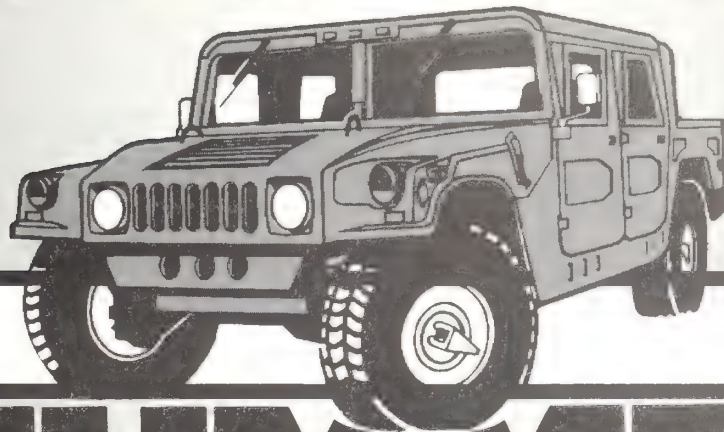
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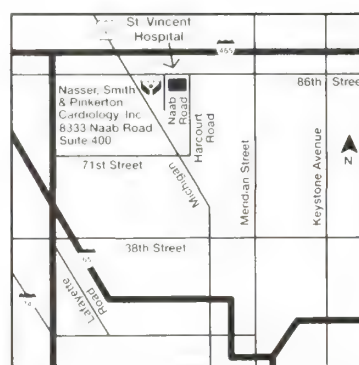


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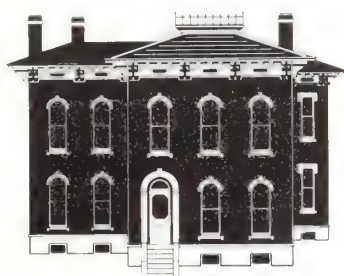
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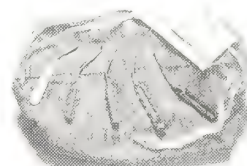
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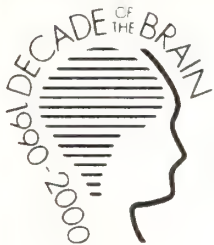
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## ■ about the cover

### Clothesline Project gives voice to women survivors of violence

"Please stop the pain" reads the message on the T-shirt on the cover of this issue of *Indiana Medicine*. For victims and survivors of domestic violence, that plaintive appeal reflects the feelings of the many women across the country who participate in The Clothesline Project.

The project is a visual display of shirts with graphic messages and illustrations that have been created by women survivors of violence or by their families and friends. Many of the shirts depict broken hearts, black eyes, bloody lips or tear-stained faces.

The purpose of the project is four-fold:

- To bear witness to the survivors as well as the victims of violence against women.
- To help with the healing process for people who have lost a loved one or who are survivors of this violence.
- To educate, document and raise society's awareness of the extent of the problem of violence against women.
- To provide a nationwide network of support, encouragement and information for other communities starting their own Clothesline Project.

The shirts testify to the impact of violence against women and communicate intense feelings of anger, loss, shame and hatred, while others convey the power to heal, the message of hope and the courage to survive. They give every woman touched by violence a voice and a place to be heard.

For decades women communicated with each other over the backyard fence while hanging clothes. For this reason, a clothesline was considered an appropriate way to display the shirts. It also symbolized the effort to air society's "dirty laundry" – the problem of violence against women.

The Clothesline represents a lifeline to help survivors join together in support of one another.

The shirts are hung side by side, as though the survivors were standing there themselves, shoulder to shoulder, bearing witness to the violence that is committed against women on a daily basis and breaking their silence.

The Clothesline Project was started by the Cape Cod Women's Agenda in Massachusetts in 1990. Since then, more than 250 Clothesline projects have begun across the United States and in seven other countries. In Indiana, projects are located in Bloomington, Fort Wayne, Hobart and Indianapolis.

Local chapters will set up Clothesline displays of the T-shirts for interested organizations. There is no charge to viewers, to people who want to create and hang a shirt or to groups that want to display the shirts.

For more information on the Indianapolis Area Clothesline Project, call Dena Perry, (317) 872-8219, or the Family Advocacy Center in Indianapolis, (317) 327-6928. □

## Ann Wrenn to be installed as AMA Alliance secretary

**A**nn Wrenn, president of the ISMA Alliance in 1988-89, has been nominated as secretary of the American Medical Association Alliance. She will be installed during the AMA-A House of Delegates meeting in Chicago in June.

Mrs. Wrenn has served as a field director for the AMA Alliance for three terms, bylaws committee chair, ad hoc member of the long-range planning committee and a member of the finance, legislation and nominating committees. She has served as an Alliance representative to the ISMA Commission on Physician Assistance and the ISMA Preventive Health Task Force, and is a past president of the Monroe Owen Medical Alliance.

Mrs. Wrenn holds a bachelor of science degree in business education and has taught business and education to high school students. She and her husband, Robert E. Wrenn, M.D., an obstetrician/gynecologist, have four children and live in Bloomington.

Mrs. Wrenn believes that the Alliance has always recognized that the concerns of the medical family are unique: the long hours, the commitment to healing and the lack of time that are the hallmarks of a physician's life. Now added to these are the stress and uncertainty

that accompanies health system reform. Concerns are voiced about the toll reform will take on patients, medical practices, insurance companies and business. Rarely do people hear about the toll the health system reform debate is taking on physicians and their families.

It may be time to get back to basics, to remember that one of the tenets that built the Alliance is our common bond as physicians' spouses. One of the services that we can offer that no other organization can is a forum in which the concerns of the medical family can be shared and through which physicians' spouses can receive support.

### ISMA Alliance candidates

The nominating committee of the ISMA Alliance met Feb. 15 and selected the following candidates for office for the 1995-96 Alliance year.

President-elect: Patty Lackey, Evansville

First vice president: Cheryl Haslitt, Muncie

Northern area vice president:

Fran Foster, Fort Wayne

Central area vice president:

Julie Hampton, Anderson

Southern area vice president:

Laurel Weddle, Columbus

Secretary: Phyllis Walker,



**Ann Wrenn**

Bloomington

Treasurer: Sharon Gilmor, Indianapolis

Valerie Gates, Valparaiso, will be installed as president during the ISMA-Alliance annual convention in October.

The nominating committee was chaired by Sue Ellen Greenlee, immediate past president, Kendallville. Members of the committee were Valerie Gates, Valparaiso; Trudy Urgena, Marion; Kay Enderle, Terre Haute; Judy Van Curen, Elkhart; Sue Schneider, Indianapolis; and Anita Davis, Terre Haute. □

## ■ from the museum

### Exhibit explores development of sports medicine

Oren S. Cooley  
Indianapolis

**T**he medical care the professional or amateur athlete receives today reflects the many successive developments experienced in medicine and society since the Victorian era.

As the calisthenics and gymnastics popular after the Civil War were replaced by cooperative games and team sports by the century's end, the type of injuries experienced and the people responsible for treating those injuries also changed. Although initially teams often asked physicians interested in sports to provide the emergency care required for athletic injuries and to serve as medical consultants, the teams' trainers typically assumed responsibility for the health care needs of athletes.

By the middle 1930s, trainers usually provided the initial medical evaluation of injuries, administered

the necessary first aid treatments and instituted conditioning and rehabilitation programs. The trainer also facilitated communication between the coach and the athlete and, when necessary, between the athlete and the physician.

A great demand for qualified health care practitioners to provide the appropriate medical care for athletes arose as the number of people participating in organized sports grew during the middle 1900s. Between the late 1930s and the middle 1950s, the establishment of professional organizations, such as the American College of Sports Medicine, increased efforts to collect data about athletic injuries and facilitated the exchange of ideas about various medical treatments for those injuries.

As a result, a team approach – with the trainer and the physician as the fundamental basis – was adopted by the late 1950s in order to decrease the prevalence of athletic injuries and to provide the proper

medical care for athletes. Sports medicine continued to evolve throughout the 20th century as intercollegiate athletic programs increased, medical and scientific advances occurred and the number of people participating in professional and amateur sports expanded.

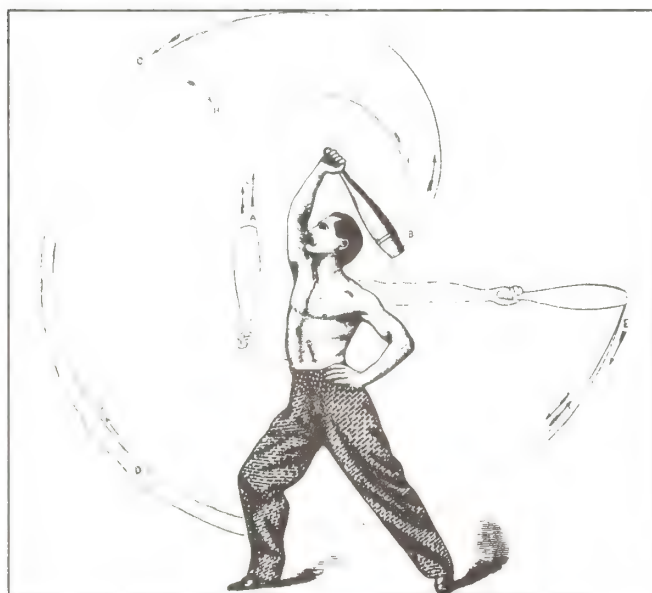
By the 1970s, teams increasingly asked orthopaedic surgeons to be present at sports events to provide immediate care to injured athletes. In addition, for both professional and amateur athletes, the scope of sports medicine had expanded to include nutritional information, training to prevent injuries and wellness assessments.

Besides procedures and surgeries to treat various injuries, the medical care of the athlete today may include nutritional information, psychological evaluations, rehabilitation programs and wellness assessments. In addition, numerous professional organizations exist today to assist athletes and those people who care for athletes in maintaining and enhancing their health, fitness and performance.

The current exhibit on the history of sports medicine at the Indiana Medical History Museum explores not only the development of the field of sports medicine but also the techniques used to treat various sports related injuries. The museum, located at 3045 W. Vermont St., Indianapolis, is open from 10 a.m. to 4 p.m., Wednesday through Saturday, and other times and days by appointment.

For more information, contact the museum at (317) 635-7329. □

*The author is director of the Indiana Medical History Museum in Indianapolis.*



**A person uses an Indian club to perform various calisthenic exercises, as indicated by this 1866 illustration. As calisthenics were replaced by team sports by the end of the 19th century, the type of injuries and the people responsible for treating those injuries changed.**



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 2 - Pres: Gene Bourgasser, Sullivan  
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 Annual Meeting: May 11, 1995  
 3 - Pres: Daniel Cannon, New Albany  
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 Annual Meeting: May 17, 1995  
 4 - Pres: Alan Kohlhaas, Lawrenceburg  
 Secy: Gerald Bowen, Lawrenceburg  
 Annual Meeting: May 3, 1995  
 5 - Pres: Warren Macy, Greencastle  
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 Annual Meeting: May 25, 1995  
 6 - Pres: Helen Steussy, New Castle  
 Secy: to be announced  
 Annual Meeting: May 10, 1995  
 7 - Pres: Craig Moorman, Franklin

Secy: John Schneider, Indianapolis

Annual Meeting: to be announced  
 8 - Pres: Kathleen A. Galbraith, Portland  
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 Annual Meeting: June 7, 1995  
 9 - Pres: Herschell Servies, Lebanon  
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 Annual Meeting: June 14, 1995  
 10 - Pres: Frank Hieber, Munster  
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 Annual Meeting: April 29, 1995  
 11 - Pres: Agnes Kenny, Peru  
 Secy: Jack Higgins, Kokomo  
 Annual Meeting: Sept. 13, 1995  
 12 - Pres: Joseph Manthey, Liberty Center  
 Secy: David Haines, Warsaw  
 Annual Meeting: Sept. 14, 1995  
 13 - Pres: Donald Smith, South Bend  
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## ■ cme calendar

### IU School of Medicine

The Indiana University School of Medicine has announced the following courses:

- May 18** – IU Hospitals Home Care, University Place Conference Center.
- June 21, July 19, Aug. 16** – Graduate Course in Pediatrics, Riley Hospital for Children.
- June 30** – Review and Interpretation of the 1995 ASCO Meeting, University Place Conference Center.
- July 10-19** – 80th Annual Anatomy and Histopathology of the Head, Neck and Temporal Bone, IU Medical Center Campus.

For more information, call the IU School of Medicine, Division of Continuing Medical Education, (317) 274-8353 or 1-800-622-4989.

### Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology will present the following CME courses:

- Aug. 23** – Practice Management Seminar, Ritz Charles, Indianapolis.
- Nov. 3** – Emergency Physician Seminar, Ritz Charles, Indianapolis.

For registration information, call Janet McAbee at (317) 338-6089.

### HIV Update

Reid Hospital in Richmond will sponsor an evening seminar titled "HIV Update" May 23.

For registration information, call Marie Hopper, (317) 983-3112.

### Biliary, Pancreatic Disease

The Fourth International "Hands-On" Therapeutic ERCP Conference will be held June 2 through 4 at the Baltimore Marriott Inner Harbor hotel in Baltimore. This year's topic is "Didactic and Hands-On Therapeutic Orientation to Biliary and Pancreatic Disease." Maurice Arregui, M.D., of Indianapolis is the course director.

The conference is sponsored by the Society of American Gastrointestinal Endoscopic Surgeons. For more information, call Education Design at 1-800-832-5115.

### University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- July 9-12** – 21st Annual Mackinac Island Course: Advances in the Management of Infectious Diseases, Grand Hotel, Mackinac Island, Mich.
- July 23-25** – Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management with a Special Focus Session for Technologists, Grand Traverse (Mich.) Resort Village.
- Aug. 13-16** – Internal Medicine Update, Grand Hotel, Mackinac Island, Mich.
- Aug. 24-27** – Cardiology Update, Grand Hotel, Mackinac Island, Mich.

For registration information, call (313) 763-1400.

### George Washington

The George Washington University Medical Center in Washington, D.C., will sponsor these CME courses:

- June 7-9** – Third International Symposium on Maritime Health, Maritime Institute of Technology and Graduate Studies, Baltimore.
- June 7-10** – Second Annual Intensive Review of Internal Medicine, Washington Marriott Hotel, Washington, D.C.
- June 17-21** – 17th National Lesbian and Gay Health Conference and 13th Annual AIDS/HIV Forum, Hyatt Regency, Minneapolis.
- June 24-28** – Third Annual Board Review in Family Medicine, Marriott Crystal Gateway Hotel, Arlington, Va.

For more information, call (202) 994-4285. □

### How to submit CME news

To publish news of your CME courses, mail information to Indiana Medicine, 322 Canal Walk, Indianapolis, IN 46202-3268 or fax it to (317) 261-2076. News is due two months before publication (e.g., May 20 for the July/August issue). □



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### **COLA offers toll-free help to physicians**

Physicians and their staffs can receive timely answers to in-office laboratory testing questions by calling the Commission on Office Laboratory Accreditation (COLA) toll-free number, (800) 298-8044. The number connects to the COLA Customer Service Center, which is staffed by medical technologists, and will be in operation Monday through Friday from 9 a.m. to 5 p.m., Eastern time.

The toll-free service is made possible through a cooperative agreement with the Centers for Disease Control and Prevention. The agreement also will enable COLA to conduct an educational needs assessment and analysis of more than 7,000 office laboratories, develop informational fact sheets for distribution via fax or mail and develop a database to determine laboratory testing complexity.

COLA is a non-profit, federally-approved educational and accreditation organization for physicians performing laboratory testing.

### **Orthopaedic practices join new statewide network**

The Specialty Physician Alliance Network (SPAN), a joint venture of The Indiana Hand Center and Orthopaedics Indianapolis, has added several orthopaedic practices as the first effort in developing a statewide specialty network.

The new practices are Orthopaedics Northeast in Fort Wayne, Central Indiana Orthopaedics in Muncie, Specialty Centers for Orthopaedic and Rehabilitative Excellence in Indianapolis, Orthopaedic and

Sports Medicine Center of Northern Indiana in Elkhart, The Orthopaedics Centers in Gary, Southern Indiana Orthopaedics in Columbus and The Bone and Joint Center in Bloomington.

As a statewide network, SPAN will be able to negotiate contracts with payers by serving as the marketing and contracting agent for specialty groups and individuals. The arrangement simplifies the contracting process and centralizes the utilization management and quality assurance considerations for payers and employers.

### **Accountable health care focus of IU research**

The Indiana University School of Public and Environmental Affairs has received a quarter-million dollar grant from the Robert Wood Johnson Foundation to study accountability in health care delivery.

Professor Marc A. Rodwin, a health policy analyst on the IU faculty, will direct the 36-month research project. The project will explore the quest for accountable health care, examining the accountability of physicians, administrators and organizations to consumers of health care, payers and the general public.

The issue of accountability will be looked at in the context of managed-care organizations because, Rodwin said, "these so-called 'alternative' delivery systems will soon be the dominant way in which Americans receive medical care." Particular emphasis will be placed on examining the tensions and trade-offs in accountability to competing parties.

### **Groups team up to support primary care**

A cooperative agreement between the Indiana State Department of Health and the Indiana Primary Health Care Association will help in efforts to support primary care in identified underserved areas and populations of Indiana.

Key components of the agreement include:

- Physician to community population ratios will continue to be determined. As of October 1994, 30 counties of Indiana were in whole or part designated health professional shortage areas, and 46 counties were designated in whole or in part as medically underserved areas.
- A state-based plan for local community planning to address the issue is being developed by the ISDH and will provide data and resource access to primary health care on an annual basis.
- Indiana will increase its efforts to participate in the National Health Service Corps scholarship and loan repayment program for doctors who agree to practice in medically underserved communities.
- The ISDH and the IPHCA have cooperated to receive federal funding to encourage fellowship grants for medical students and residents, as well as mid-level practitioners, to experience practice in rural settings and increase their awareness of career opportunities in rural communities.
- The groups want to develop additional Community Health Centers to provide services to medically underserved populations.

### **IU receives grant to study heart repair**

Researchers at the Indiana University School of Medicine in Indianapolis have received an \$8 million National Institutes of Health grant that may result in a day when genetically altered cells will mend damaged hearts, a feat the heart is incapable of achieving.

Douglas Zipes, M.D., the principal investigator, says the grant will advance research, now on the molecular level, to treatment at the bedside of patients who have suffered heart attacks, congestive heart failure and sudden cardiac death from abnormal heart rhythms. Investigators will use Positron Emission Tomography (PET) and other basic science technologies to understand the cellular mechanisms involved in damage from heart attack, congestive heart failure and heart enlargement produced by prob-

lems such as high blood pressure. They will then attempt to repair the damaged hearts of animals by creating genetically engineered cells that have the capability of performing very specific repair processes, such as changing the electrical status of the heart to restore normal heart beats.

### **St. Vincent Hospital offers surgical fellowship**

Surgeons are eligible to apply for a one-year fellowship in surgical laparoscopy, endoscopy and ultrasound at St. Vincent Hospital in Indianapolis.

Interested physicians may send letters of inquiry with their curriculum vitae to the director of the program, Maurice E. Arregui, M.D., 8402 Harcourt Road, Suite 811, Indianapolis, IN 46260. Applications are being accepted for July 1996.

### **Report on calcium intake available from NIH**

A National Institutes of Health (NIH) consensus development statement on optimal calcium intake may be obtained from the NIH Office of Medical Applications of Research (OMAR). The report, which was prepared by a panel of experts who considered scientific evidence presented at an NIH conference, contains recommendations and conclusions concerning optimal calcium intake.

Free, single copies of the consensus statement on optimal calcium intake may be obtained from William H. Hall, Director of Communications, Office of Medical Applications of Research, National Institutes of Health, Federal Building, Room 618, 7550 Wisconsin Ave., MSC 9120, Bethesda, MD 20892-9120, (301) 496-1143. □

## **PRIMARY CARE PHYSICIANS**

Heartland Primary Care is seeking BE/BC Primary Care physicians who desire to join a progressive, hospital-employed group practice. You'll be involved in all aspects of family medicine except obstetrics, providing clinical coverage at a new hospital-based ambulatory care center and satellite offices in St. Joseph and nearby communities. To allow flexibility for your personal life, you'll share call with other members of the Heartland Health System Department of Primary Care.

Heartland Health System is a 600-bed bi-campus regional referral center, serving 29 counties in Northwest Missouri and adjacent areas of Kansas, Iowa and Nebraska.

- Guaranteed salary of \$135,000 per year
- Medical student loan repayment options
- Malpractice insurance
- Health and life insurance
- Vacation
- Relocation expenses are provided.

For more information call Rhonda, 800-455-2480 or Heidi, 800-455-2485. Send CV to Heartland Health System, Medical Staff Development, 5325 Faraon, St. Joseph, MO 64506 or Fax to 816-271-6146.



**Heartland  
Health System**

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## ■ obituaries

### **Arthur G. Blazey, M.D.**

Dr. Blazey, 87, a retired family physician, died Feb. 18, 1995, at St. Joseph's Hospital in Huntingburg. He lived in Santa Claus, Ind., and had practiced in Washington, Ind., from 1935 to 1977.

He was a 1933 graduate of Hahnemann Medical College of Philadelphia and a veteran of World War II.

Dr. Blazey was on the staff of Daviess County Hospital from 1936 to 1977. He was a fellow of the American Society of Abdominal Surgeons and a member of the American Association of Physicians and Surgeons.

### **Donald F. Buehner, M.D.**

Dr. Buehner, 76, a retired Evansville family physician, died Feb. 17, 1995, at his home.

He was a 1950 graduate of the St. Louis University School of Medicine and a U.S. Army veteran of World War II.

Dr. Buehner practiced in Evansville from 1951 to 1988. He was a charter diplomate of the American Board of Family Practice, a fellow of the American Academy of Family Physicians and a past president of St. Mary's Medical Center staff.

### **William F. Howard, M.D.**

Dr. Howard, 66, Nashville, Ind., died Feb. 18, 1995, at his home. He was in family practice in Nashville and had an obstetrics-gynecology practice in Bloomington.

He was a 1954 graduate of the Indiana University School of Medicine and a Marine Corps veteran.

Dr. Howard was a professor of ob/gyn at the University of Iowa before starting a practice in

Bloomington. During his residency at the Indiana University Medical Center, he was honored by the Central Association of Ob-Gyn for research work in toxemia during pregnancy.

### **Arnold L. Johnson, M.D.**

Dr. Johnson, 85, a retired Gary obstetrician and gynecologist, died Feb. 17, 1995.

He was a 1937 graduate of the Howard University College of Medicine.

Dr. Johnson founded the prenatal clinic of Methodist Hospital in Lake County and provided his services to the clinic at no charge. He was staff physician at Methodist Hospitals and St. Mary Mercy Hospitals in northwest Indiana and served on the teaching faculty of Purdue Calumet of Hammond and Indiana University Medical School Northwest. He was a fellow of the American College of Obstetricians and Gynecologists. Dr. Johnson retired from the clinic in 1985 and from practice in 1989.

### **Andrew L. Lutz, M.D.**

Dr. Lutz, 80, a retired Highland obstetrician and gynecologist, died Jan. 11, 1995.

He was a 1951 graduate of the Medizinische Fakultät der Johann Wolfgang Goethe in Germany.

Dr. Lutz had been on the staff at St. Margaret Mercy North and The Community Hospital in Munster.

### **Howard R. Marvel, M.D.**

Dr. Marvel, 72, a retired West Lafayette allergist, died Jan. 19, 1995, at his home.

He was a 1948 graduate of

the University of Michigan Medical School and an Army Medical Corps veteran.

Dr. Marvel was on the staff at Arnett Clinic from 1956 until his retirement in 1986. He had been a clinical assistant professor of medicine at Indiana University's Lafayette Center for Medical Education and on the staff at St. Elizabeth Hospital Medical Center and Home Hospital. After his retirement, he served on the staff of the Purdue Student Hospital from 1987 to 1990.

### **Donald C. Miller, M.D.**

Dr. Miller, 68, a Cedar Lake family physician, died Feb. 27, 1995, at St. Anthony Medical Center in Crown Point.

He was a 1950 graduate of the Indiana University School of Medicine.

### **Richard C. Pryor, M.D.**

Dr. Pryor, 85, a retired Indianapolis family physician and pharmacist, died Jan. 28, 1995.

He was a 1942 graduate of the Indiana University School of Medicine.

Dr. Pryor was a family physician for 35 years, retiring in 1979, and previously was a pharmacist for 10 years. He was a member of the American Academy of Family Physicians.

### **Eugene E. Schmidt, M.D.**

Dr. Schmidt, 74, a Fort Wayne anesthesiologist, died March 4, 1995, at his home.

He was a 1945 graduate of the Indiana University School of Medicine and an Army veteran of World War II. He served as a captain in the U.S. Medical Corps at the Fort Custer psychiatric



hospital in Battle Creek, Mich.

He was a co-founder of Associated Anesthesiologists in 1950 and a retired staff member of Lutheran Hospital.

**Byron L. Steger, M.D.**

Dr. Steger, 84, a retired U.S. Army physician, died Jan. 27, 1995. Formerly of Indianapolis, he was

living in San Antonio, Texas, at the time of his death.

He was a 1933 graduate of the Ohio State University College of Medicine.

Dr. Steger held the title of major general and received 19 military decorations, including the Distinguished Service Medal, the Legion of Merit and the Bronze

Star. He was a diplomate of the American Board of Preventive Medicine and a fellow of the American College of Preventive Medicine, the American Public Health Association and the American College of Physicians. He was a member of the Association of Military Surgeons. □

**D**r. James W. Strickland, founder of The Indiana Hand Center in Indianapolis and chairman of hand surgery at St. Vincent Hospital, was elected president of the American Academy of Orthopaedic Surgeons. Dr. Strickland is the first Indiana orthopaedist to hold the position.

**Dr. Jay L. Grosfeld**, chairman of the department of surgery at the Indiana University School of Medicine, was named chairman of the surgical section of the American Academy of Pediatrics.

**Dr. Stephen J. Jay** was named assistant dean of continuing medical education at the Indiana University School of Medicine. He served as senior vice president of academic and medical affairs of Methodist Hospital in Indianapolis the past 14 years.

**Dr. Maurice Arregui**, an Indianapolis surgeon, presented two lectures at the annual conference of the Society of American Gastrointestinal Endoscopic Surgeons in Orlando, Fla. He spoke on "Hernia: Outcomes and Costs - Indications Based on Cost and Outcome" and "Anatomy According to the Laparoscope - Inguinal Region and Retroperitoneal Lymph Nodes." He spoke on laparoscopic ultrasound, the role of ERCP in managing common bile duct stones and laparoscopic common bile duct explorations during a workshop at the Yale University School of Medicine.

**Dr. Carl E. Otten**, with the Community Hospitals Indianapolis Occupational Health Program, has been certified as a specialist in occupational medicine by the American Board of Preventive Medicine.

**Dr. Stephen Perkins**, of Meridian Plastic Surgery Center in

### Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

#### January

Archangel, Cesar S., Jeffersonville  
Cook, Ian H., Fort Wayne  
Gaddis, Gary M., Yorktown  
Herrell, Michael A., Evansville  
Kuhlman, Deborah S., Kokomo  
Lloyd-Jones, Trevor T., Cumberland  
Roch, L. Marshall, Muncie  
Sommer, Diane Rita Marie, Carmel

#### February

Alonso, Robert J., Indianapolis  
Anderson, Ernest, Fort Wayne  
Asuncion, Leyte B., Boonville  
Barrett, Warrick L., Indianapolis  
Benedict, Harold G., Anderson  
Black, Kenneth A., Portage  
Bloch, Ted, Indianapolis  
Blumenthal, Kenneth W., Portage

Farag, Rafik S., Peru  
Galante, Gustavo E., Munster  
Gluek, Louis A., Munster  
Gupta, Narendra K., Logansport  
Haynes, John T., Indianapolis  
Heavilon, Jeffrey A., Muncie  
Jones, Christopher S., Indianapolis  
Judge, Robert E., Berne  
Knoll, Eric Y., Indianapolis  
Lane, Frederick R., Indianapolis  
Lee, Randall A., Martinsville  
Mangahas, Jovencio P., East Chicago  
Nesbitt, William A., Connersville  
Pontaoe, Alejandro G., Evansville  
Shelton, N. Philip, Vincennes  
Sheth, Devdas N., Evansville  
Shields, James K., Otterbein  
South, Terry A., Evansville  
Turney, Albert W., LaGrange  
Zieg, R. Daniel, Indianapolis □

Indianapolis, spoke at a symposium on "Advanced Rejuvenative Plastic Surgery of the Face, Neck, Scalp and Nose: What's New, Tried, Tested and True" in Birmingham, Ala.; he led discussions on the trichloroacetic facial peel and submentoplasty and served as a panelist for a discussion of chemical facial peels. He lectured on tip rhinoplasty and total lobular reconstruction in secondary rhinoplasty at a seminar on "Rhinoplasty: The Fundamentals" at Penn State College of Medicine in Philadelphia.

**Dr. Ruchir Sehra**, an Indianapolis pediatrician, was named to the National Board of Medical Examiners by the Governing

Council of the Resident Physician Section of the AMA.

**Dr. Steven Isenberg** was inducted into the American Society for Head and Neck Surgery at its meeting in Palm Desert, Calif.

**Dr. Glenn A. Loomis**, chief family practice resident at Community Hospitals in Indianapolis, and **Dr. Janet E. Roepke**, chief pathology resident at Ball Memorial Hospital in Muncie, have received the AMA/Glaxo Achievement Award in recognition of outstanding leadership skills. The awards were presented at the AMA National Leadership Conference in Washington, D.C.

**Dr. Jeffery Pierson** of Hoosier Orthopaedics and Sports

Medicine in Indianapolis presented a paper on "Techniques of Extraction of Well-Fixed Cemented and Cementless Implants in Revision Total Hip Arthroplasty" at the annual Garceau Wray lecture at the Indiana University School of Medicine.

**Dr. Frederick M. Kelvin**, a radiologist at Methodist Hospital in Indianapolis, was a visiting professor at the University of Arkansas in Little Rock. He presented lectures on "Radiologic Management of Small Bowel Obstruction," "Colorectal Carcinoma: A Radiologist's Perspective" and "Investigation of Disorders of the Female Pelvic Floor."

**Dr. Rick C. Sasso** of Indianapolis Neurosurgical Group is the first author of an article titled "Occipitocervical Fusion with Posterior Plate and Screw Instrumentation: A Long-Term Follow-up Study" that was published in *Spine*.

**Dr. Francis W. Price Jr.** and **Dr. William E. Whitson**, co-directors of Corneal Consultants of Indiana in Indianapolis, have been named principal investigators for a study on laser-assisted in situ keratomileusis (LASIK). Corneal Consultants is one of six practices selected by Chiron Vision of Irvine, Calif., for the study comparing LASIK and photorefractive keratectomy, or standard excimer laser surgery.

**Dr. Beth Buchanan**, a family physician, was elected medical staff president at Hancock Memorial Hospital in Greenfield, and **Dr. Donald P. Snyder**, an obstetrician/gynecologist, is the vice president.

**Dr. Thomas L. Sevier**, of Central Indiana Sports Medicine in Muncie, was elected to fellowship in the American College of Physi-

cians.

**Dr. Patrick Moore**, a New Albany anesthesiologist, has written, composed, performed and recorded an album titled "Alternatives to Violence." The music is a mix of rock, new age and country.

**Dr. Robert D. Glassman**, a cardiologist, was named chief of staff of Hendricks Community Hospital in Danville. Other officers are **Dr. Charles H. Tripple**, a family physician, vice chief of staff, and **Dr. Robert D. Aiello**, a family physician, secretary-treasurer.

**Dr. James E. Stephens**, a Brazil family physician, participated in the Men's Senior Baseball League World Series in Arizona.

**Dr. Betty Dukes**, a retired Dugger family physician, was named Physician of the Year by the Indiana Medical Review Organization.

**Dr. William J. Tuley** was named medical director of chemical dependency services at Charter

Behavioral Health System of Indiana in Evansville.

**Dr. Rafik S. Farag**, a general surgeon, was elected president of the medical staff at Dukes Memorial Hospital in Peru. Also elected were **Dr. Richard E. Galbreath**, a family physician, vice president; and **Dr. Christi Redmon**, an obstetrician/gynecologist, secretary.

**Dr. Homer A. Ferree**, a family physician, was named chief of staff at Floyd Memorial Hospital in New Albany.

**Dr. J. Douglas Smith**, a family physician, was elected president of the medical staff of Community Hospital of Anderson and Madison County. Other officers are **Dr. Joseph Copeland**, an obstetrician/gynecologist, chief of staff; **Dr. Salah Elsharty**, a urologist, vice president; and **Dr. Joseph Porcaro**, a radiologist, secretary-treasurer.

**Dr. James Pease**, a family

## Indiana Medical Women's Association established

An Indiana chapter of the American Medical Women's Association has been established.

New officers are Jane Howard, M.D., an Indianapolis cardiologist, president; Kathleen Warfel, M.D., an Indianapolis pathologist, vice president; Marian McNamara, M.D., an Indianapolis vascular surgeon, secretary; and Molly Garau, M.D., an Indianapolis family physician, treasurer.

The mission of the newly-founded group is:

1. To educate the public and physicians about women's medical issues.

2. To interact with the student branch by providing information to students and/or residents on topics such as contracts and practice management.

3. To become a liaison between associations such as the Osteoporosis Society and the Thyroid Association and the public.

4. To publish a national and/or local newsletter.

5. To hold local quarterly meetings to update physicians on different areas of medicine.

Anyone interested in joining the association may contact any of the officers. □



## people

physician, was elected chief of staff at Johnson Memorial Hospital in Franklin. **Dr. Paul Vessely**, a family physician, was elected secretary.

**Dr. Bruce Fowler**, a family physician, was named medical director of the new MEC Medical Center in Newburgh.

**Dr. Mark Hochstetler**, vice president for managed health care at Parkview Memorial Hospital in Fort Wayne, was appointed to the Indiana Hospital Association's Council on Data for a three-year term.

**Dr. Eugene M. Gillum**, a Portland family physician, received a Lifetime Achievement Award from the Portland Area Chamber of Commerce.

**Dr. M.S. Krishna**, a pediatrician, was named chief of staff at Gibson General Hospital in Princeton. Other officers are **Dr. Hassah Rayes**, a general surgeon, vice chief of staff, and **Dr. A.C. Kumar**, an internist, secretary and treasurer. □

### New ISMA members

**Virendra K. Agarwal**, M.D., Bedford, internal medicine.

**Alexander Ajlouni**, M.D., Indianapolis, anesthesiology.

**Muyesser N. Alnigenis**, M.D., Indianapolis, internal medicine.

**Allan M. Arkush**, D.O., Indianapolis, general surgery.

**Elizabeth M. Ashworth**, M.D., Vincennes, thoracic surgery.

**Keith R. Baker**, M.D., Bedford, internal medicine.

**F. Keith Bean**, M.D., Indianapolis, obstetrics and gynecology.

**J. Edwin Bolander II**, M.D., Indianapolis, nephrology.

**John L. Bormann**, M.D., Fort Wayne, diagnostic radiology.

**Gregory E. Buck**, M.D.,



**Robert L. Rudesill**, M.D., center, received the first **Joseph E. Walther**, M.D., Distinguished Physician Award from Winona Memorial Hospital in Indianapolis. Pictured with Dr. Rudesill are **Andrew Moore**, M.D., left, medical staff president, and **Ramon Dunkin**, M.D., chairman of the board of trustees. The medical staff established the award to recognize Dr. Walther's more than 50 years of outstanding service to the medical profession and the community. The recipient of the annual award exemplifies the same qualities of service and dedication. Dr. Rudesill, an internist, has been on the Winona staff since 1967.

**Bremen**, family practice.

**David A. Campbell**, M.D., Fort Wayne, rheumatology.

**Joseph R. Car**, M.D., Spencer, internal medicine.

**Reynaldo A. Carandang**, M.D., Vincennes, internal medicine.

**Ana S. Cardenas**, M.D., South Bend, family practice.

**George A. Curry II**, M.D., Evansville, neurology.

**Judy L. Davis**, D.O., Valparaiso, ophthalmology.

**Michael L. Delk**, M.D., Huntingburg, anesthesiology.

**David M. Dresner**, M.D., New Albany, gastroenterology.

**Jack M. Drew**, M.D., New Castle, diagnostic radiology.

**Thomas F. Eichhorn**, M.D., Anderson, cardiovascular diseases.

**Keith E. Ennis**, M.D., Kokomo, family practice.

**Julie K. Fetters**, M.D., Indianapolis, cardiovascular diseases.

**Jon D. Frazier**, M.D., South Bend, radiation oncology.

**William R. Funderburg Jr.**, M.D., Vincennes, anesthesiology.

**Jeffrey Greenberg**, M.D., Indianapolis, orthopaedic surgery, hand surgery.

**Douglas S. Hale**, M.D., Indianapolis, obstetrics and gynecology.

**Thomas S. Hastetter**, M.D., Evansville, obstetrics and gynecology.

**Fawzi Jerjes F. Hattab**, M.D., New Albany, psychiatry.

**Thomas A. Hawk**, M.D., Danville, anesthesiology.

**Gregory S. Hellwarth, M.D.,**  
Muncie, orthopaedic surgery.

**Lloyd D. Holm, D.O.,**  
Madison, obstetrics and gynecology.

**Thomas J. Holt, M.D.,**  
Michigan City, urological surgery.

**Darrel L. Huff, M.D.,**  
Plainfield, ophthalmology.

**Mark U. Kyker, M.D.,**  
Indianapolis, anesthesiology.

**Joseph J. Lach, M.D.,**  
Hammond, general surgery.

**John R. Larson, M.D.,**  
Bremen, family practice.

**Tina M. Lawson, M.D.,** Fort  
Wayne, family practice.

**Lloyd D. Lorenz, M.D.,** Peru,  
family practice.

**Colleen M. Madden, M.D.,**  
Indianapolis, radiology.

**Aleksander I. Malakhov,**  
M.D., Indianapolis, internal  
medicine.

**Lea Ann Marlow, M.D.,**  
Floyds Knobs, family practice.

**Gerald S. Maxwell, D.O.,**  
Fort Wayne, family practice.

**Donald J. Michael, M.D.,**

Mishawaka, psychiatry.

**Clint E. Myers, M.D.,** New  
Castle, anesthesiology.

**John Brian O'Donnell, M.D.,**  
Bloomington, family practice.

**Hugh T. Owen, M.D.,**  
Jeffersonville, dermatology.

**Virendra A. Parikh, M.D.,**  
Fort Wayne, colon and rectal  
surgery.

**Chandrakant R. Patel, M.D.,**  
East Chicago, general practice.

**Mitchell A. Pfeiffer, M.D.,**  
Indianapolis, pulmonary diseases.

**James D. Pike, D.O.,** India-  
napolis, pulmonary diseases.

**Rolando M. Quilaton, M.D.,**  
Indianapolis, family practice.

**Ganapathy S. Ramanathan,**  
M.D., Bedford, cardiovascular  
diseases.

**Stephen K. Reed, M.D.,** Fort  
Wayne, cardiovascular diseases.

**Kenneth B. Robertson, M.D.,**  
South Bend, internal medicine.

**Dawn M. Sabau, M.D.,**  
Kokomo, internal medicine.

**Christopher Schrodt, M.D.,**  
Indianapolis, family practice.

**Pamela R. Seaman, D.O.,**  
Michigan City, obstetrics and  
gynecology.

**Allen E. Shepherd, M.D.,**  
Portland, general surgery.

**Richard L. Stout, M.D.,**  
Martinsville, colon and rectal  
surgery.

**Brian S. Sucharetza, M.D.,**  
Mishawaka, nephrology.

**Minati D. Swofford, M.D.,**  
Anderson, dermatology.

**John S. Tetrack, M.D.,**  
Lebanon, family practice.

**James W. Tieman, M.D.,**  
South Bend, family practice.

**Blake E. Titzer, D.O.,** Evans-  
ville, family practice.

**Paula M. Toth, M.D.,** South  
Bend, neurology.

**Margaret R. Troxell, D.O.,**  
Marion, family practice.

**Giridhar Rao Veerula, M.D.,**  
Fort Wayne, pediatrics.

**Maureen L. Watson, M.D.,**  
Columbus, radiology. □

## ■ classifieds

**OPPORTUNITIES FOR PEDIATRICIAN AND/OR FAMILY PRACTICE PHYSICIANS:** Contractual part-time positions available in pediatric and adolescent clinics. Flexible hours. Hourly compensation based on training, experience and qualifications. Contact Wendell Riggs, M.D., Community Health Clinic, 1118 N. 15th St., Lafayette, IN 47904, (317) 448-1640.

**IMMEDIATE OPENING** for BC/BE family practitioner with ER experience to staff hospital-based, fast track/express care center located within St. Vincent Hospital ED, Indianapolis. Full benefits, including occurrence malpractice, health and disability insurance, fees and dues paid, paid vacation, CME allowance and participation in pension plan, are offered. Please send CV to Dr. Susan Stephens, 11011 Ditch Road, Carmel, IN 46032, (317) 844-9640.

**EMERGENCY MEDICINE, INDIANAPOLIS:** Excellent opportunity for BC/BP physician to join ED staff of 14 physicians at 620-bed northside suburban hospital and nearby 100-bed satellite hospital with joint annual volume of 53,000 patient visits. Physician-owned group offering a total benefit package that includes highly competitive salary, occurrence malpractice, health insurance, disability, educational reimbursement, fees and dues paid, 100 hours paid vacation the first year. Corporate membership and increasing pay and vacation time anticipated after the first year. 1825 hours partially double covered. Safe, family-oriented location with great schools and housing, amateur and professional sporting events and expanding economy. Send CV to Dr. Susan Stephens, 11011 Ditch Road, Carmel, IN 46032, (317) 844-9640. May also call Dr. Steve Jardina, (317) 846-9351.

**EMERGENCY MEDICINE** - A full-time opportunity for an emergency physician is available for an ED in a suburb of Indianapolis; the annual

volume is approximately 16,000. An excellent benefit package is included. If qualified and interested, contact Lee Sredzinski, M.D., 395 Westfield Road, Noblesville, IN 46060, (317) 776-7107.

**FOR SALE:** 2 matching Ritter hydraulic exam chairs, \$1,000 each. Birtcher direct current defibrillator, Model B, \$1,000. Shampaign OB/GYN table, Model 2605NL, \$1,200. AMSCO electric table, Model 2080, \$1,600. Exam lights, floor, ceiling and rail. Hydrotherapy tubs. Autoclaves. Microscopes, many models. Bacterial incubators, various sizes. Pediatric scales, digital and manual. X-ray viewers and cassettes. Ultrasound cleaner, 10x14x10D. Ultrasound therapy unit. For complete list, send \$3. Call, fax or write Byron Bernard, 1555 Dixie Highway, Covington, KY 41011, (606) 581-5205.

**115-PHYSICIAN MIDWEST MULTI-SPECIALTY** seeking BE/BC candidates: dermatology, family medicine, pulmonology. Serving 14 counties with a population draw of over 320,000. Guaranteed salary first two years, relocation expenses, CME funds, paid professional liability, investment plans, all part of the many benefits. A safe, thriving family community with stable economy offers a rewarding quality of life. Through Purdue University we enjoy academics, cultural events, entertainment and Big 10 sports. Physician Recruitment, Arnett Clinic, P.O. Box 5545, Lafayette, IN 47904, (317) 448-8000, 1-800-899-8448.

**CENTRAL INDIANA** medical consulting organization seeking permanent part-time board certified/eligible family practitioner, internist or OM physician to provide consulting services and health evaluations for business and public safety organizations. Flexible schedule, unique opportunity and excellent potential for growth. Please send curriculum vitae to P.O. Box 44142, Indianapolis, IN 46244.

**PROFESSIONAL OFFICE BUILDING** to lease in Kokomo, half-mile from Howard Community Hospital and 4 miles from St. Joseph Hospital, 2 blocks from U.S. 31, at 3904 Southland Ave., up to 2,466 square feet. Previously occupied by an internist and an accountant. Located on a street with 15 other physicians, dentists, other professionals. Lawn and shrub care, mowing, snow removal included. Utilities extra. Completely and newly decorated with all new carpet, tile, ceiling, walls, vertical blinds, handicapped entrance, paved lighted parking. Private back entrance, kitchen, 2 bathrooms, one handicapped accessible. Kokomo is a fast-growing community with excellent opportunity for family practitioner or specialist physician. Contact Ampe Realty, 525 W. Alto Road, Kokomo, IN 46904-2164, (317) 453-2123.

**NOTRE DAME FANS** - Memorial Hospital, South Bend, Ind., is accepting applications for BE/BC IMs and FPs. OB optional, salaried position/production bonus, group call coverage, teaching hospital. Contact Vivian M. Luce, 1-800-765-3055, Cejka & Co., or fax CV for immediate attention, (314) 726-3009.

**FAMILY PRACTITIONER** - Part-time position (12-24 hours/week evenings and weekends) in a hospital-sponsored urgent care center in a new facility in Chesterton, Ind. Competitive wage and malpractice coverage provided. Send CV to Chief Operating Officer at Porter Memorial Hospital, 814 LaPorte Ave., Valparaiso, IN 46383.

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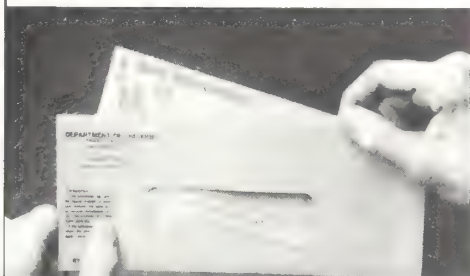
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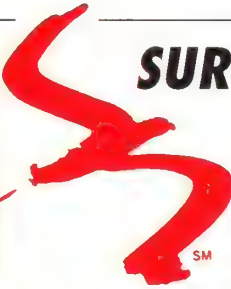
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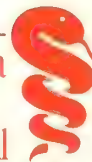
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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

July/August 1995

Vol. 88, No. 4



**Unconventional medicine in Indiana**





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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

July/August 1995

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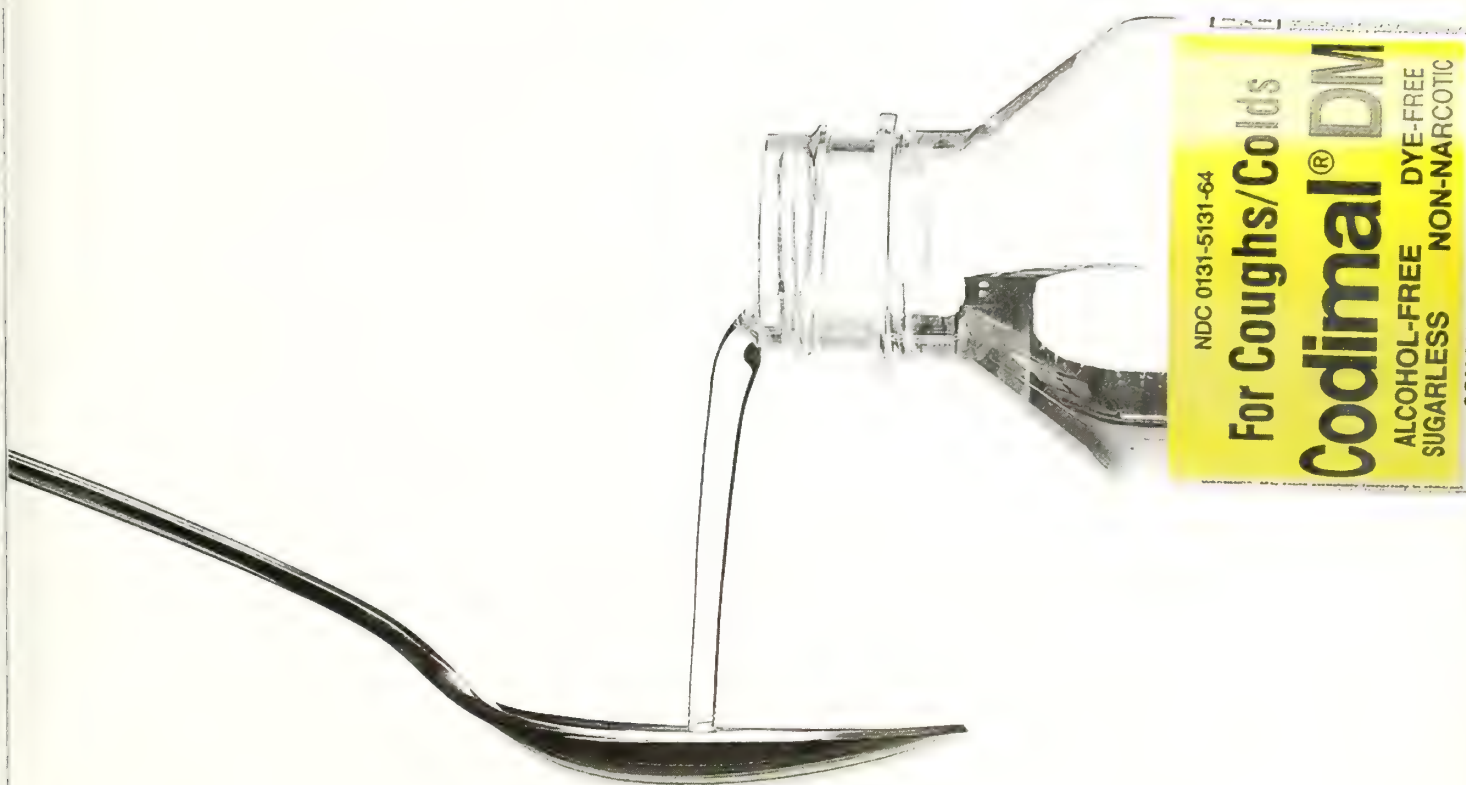
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## ISMA annual convention to focus on managed care

The ISMA will be "Shining the Light on Managed Care" at its annual convention, scheduled for Oct. 20 through 22 at the Radisson Hotel at Keystone at the Crossing in Indianapolis. The theme will be carried out at a morning program Saturday, Oct. 21, on "The Changing Environment of Health Care Delivery." The program on managed care will include the following speakers: Scott Weingarten, M.D., M.P.H., director of health services research at Cedars-Sinai Medical Center in Los Angeles; Gary Erskine, administrator of the Arnett Clinic in Lafayette; Douglas D. French, president and CEO of St. Vincent Hospital in Indianapolis; Steven F. Isenberg, M.D., Indianapolis, Project Solo; Ben Park, M.D., Indianapolis, president of American Health Network; and J. Patrick Rooney, Indianapolis, chairman of Golden Rule Insurance.

The convention will begin with a trade show breakfast Friday, Oct. 20, followed by the opening session of the ISMA House of Delegates. ISMA members are encouraged to submit resolutions to the House. Resolutions should be sent to Janice Herring at the ISMA by Aug. 21.

Fred Barnes, political commentator and senior editor at *The New Republic*, will speak Saturday, Oct. 21, at the annual IMPAC luncheon. A convention registration brochure has been mailed to all ISMA members.

## New rule affects prescriptions for controlled substances

Controlled substances prescriptions must be written on security paper beginning Jan. 1, 1996, under new rules passed in May by the Indiana Board of Pharmacy. The new rule requires the following:

- Security paper must be used on all controlled substances prescriptions and may be used on other prescriptions.
- Security paper must have a "void" pattern that appears when the paper is copied.
- The words "Indiana Security Prescription" must appear in watermark form on the back of the paper.
- An Rx symbol must appear in the prescription's upper right-hand side.
- Six quantity check-off boxes must be printed on the form.
- No advertisements may appear on the prescription.
- An individual, professional practice, professional association or hospital logo may appear in the upper left hand side of the blank.
- Only one prescription per blank is permitted.
- Refill options that can be circled must appear below any logo and above the signature lines.
- The prescriber's name and license number must be preprinted, stamped or manually printed on the prescription.
- The rule prohibits the names of controlled substances to be preprinted on the forms.

The ISMA is investigating a cost-effective, efficient way for physicians to order prescription pads that meet the new requirements. More information will be available later. □



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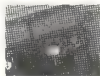


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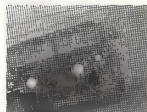
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## ■ letters to editor

### Physician urges stand against 'industrialization of medicine'

James S. Todd, M.D., the AMA executive vice president, said recently, "To date, no one has proved any one best way to deliver health care, and we have become a little bit tired of zealotry on both sides of the aisle" (*American Medical News*, March 27, 1995).

Somehow Todd has missed the point, and his stewardship is warped in quite the wrong direction. Unfortunately, medicine is still not an absolute calling; it is

still a profession, although day-by-day it becomes closer to a job.

There have always been physicians who preferred to be salaried, and that's fine, as long as there is a viable option to it. The growth of HMOs and other managed "care" groups, however, is reaching monopolistic proportions, and those organizations have no dedication to physicians' well-being, or even the well-being of clients, as long as the latter receive sufficiently adequate

service to continue buying the package. I am sorry if this zealotry on this side of the aisle is offensive to Todd, but he should be actively opposing the industrialization of medicine, not playing footsie with the Group Health Association of America and the Health Care Financing Administration. □

**George C. Manning, M.D.**  
Fort Wayne

### Are patients really 'revenue centers'?

I am troubled by the evolving format of *Indiana Medicine* and other journals of county, state and specialty organizations. I try to dutifully read through these important publications in order to stay in touch with what these organizations are doing on my behalf. What I've observed is a move toward emphasizing the "subjective" business and economic problems facing physicians today. The "objective" and scientific contributions are often relegated to the back of the journals. Both are important, but which deserves to go first? Perhaps it is time for organized medicine to re-evaluate its traditional priorities.

I continue to be amazed by the apparent lack of meaningful analysis of the impact of health care delivery market changes and legislative reforms on the essential tenets of the patient-physician relationship. The pundits of change tend to skirt the issue of how the role of the physician has

changed in a reform system of perverse incentives. The foundation of the patient-physician relationship is the trust that the physicians are dedicated first and foremost to serving the needs of their patients. No other party in the health care system has the kind of responsibility that physicians have to balance the financial needs of the "system" with the clinical needs of their patients. We are faced daily with cost benefit decisions that approach "rationing." These types of judgment calls are not part of the traditional physician role and, indeed, conflict with it. I have an inherent problem identifying patients as "revenue centers," or even as "customers," which are the titles often used in managed care. Such labels only worsen the ethical dilemmas facing physicians today.

Managed health care will march on despite the complaints of physicians, patients and families. Reform articles are written, and strategies are discussed in the

pages of *Indiana Medicine* and other county and society journals. These writings have merit when taken in the context that they are individuals' "opinions" on how medicine will change. But we as physicians must remember that these opinions are not absolute predictions of the future, and that the medical revolution is really evolution. We each have the responsibility to try to positively impact the changes that confront us and not assume that nothing can be done.

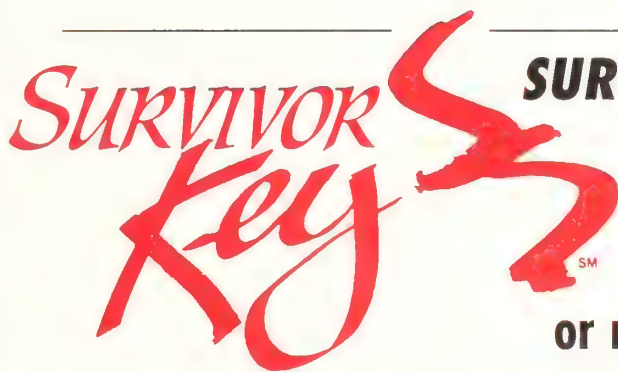
By its very nature, managed care will create clinical and ethical dilemmas for physicians. I believe our professional societies should re-evaluate our traditional priorities, put objective, scientific contributions and interviews first in our journals and save the economic "predictions" for the opinion page! □

**John J. Wernert, M.D.**  
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## Alternative care: What is it? Does it work?

George C. Manning, M.D.  
Fort Wayne

Webster's Collegiate Dictionary, 10th edition, gives seven different definitions for the word "alternative." None, however, imply a necessarily equal or equivalent choice. Alternative care is, generally speaking, a treatment administered by someone who is not a licensed allopathic physician or, if the person does hold a degree in medicine or osteopathy (which is no longer an "alternative" treatment method, although manipulation may still be so considered), the treatment is considered to be outside the mainstream of medicine. One is tempted to use the term "unconventional" medicine except that among the Papuans what is done in America is unconventional treatment.

Nurse midwives may be something of an exception to this general description because normal childbirth is not considered a disease, and therefore attending is not treatment but an assist. Unfortunately, evolution, while giving us our humanity, has also made it considerably more difficult for us to produce the next generation than it is for almost any other creature, hence, the value of someone assisting the birthing woman. Midwives did it long before men doctors made that assistance a science and a part of medicine.

Nurse practitioners and physician assistants do have a medical education. It is approximately equivalent to that of the average medical school graduate at the end of the 19th century. As such, they can function as limited physicians. Their danger comes

from the old adage that "a little knowledge is a dangerous thing."

Beyond that there is a vast array of therapies that differ from "traditional" mainstream Western medicine: chiropractic, acupuncture, colonic irrigation, naturopathy – even homeopathy – reflexology, massage therapy, traditional Chinese medicine, the ayurvedic system (Indian), faith healing and others – and do not forget voodoo and other forms of witchcraft.

There is no question but that these modalities make many people feel good. The question is: Do they alter the disease process?

The problem with the Office of Alternative Medicine (OAM) that was established in 1992 at the National Institutes of Health (NIH) is that not only is it a politicized organization, but it was organized on a non-productive model. It was organized to bring in proponents of the various therapies described above and ask those people to explain what they do and, if possible, demonstrate their techniques.

Such a mechanism might be interesting for people whose only familiarity with the various "alternative" methodologies is a recognition of the name, but unfortunately the approach has no relationship to the scientific method of investigating treatments in the mainstream of medicine.

A hundred years ago, the understanding of therapeutic outcomes in medicine was dependent almost entirely on anecdotal reports. However, science in other fields such as chemistry, biology and engineering was rapidly developing "the scientific method." This involves a reliance not only on careful, but whenever possible exact, measurement;

rigorous control of variables; a search for unrecognized variables; careful statistics; and, most importantly, questioning every assumption, every apparent outcome, every alternative.

Just after the turn of the 20th century, following the report of the commission on medical education headed by Abraham Flexner, a dramatic change occurred in American medical education. The scientific method became the basis for all investigation and teaching. Treatment methodology followed along, though even today it is far from 100% pervasive. The development by the statisticians of what is known as the prospective, randomized, double-blinded, therapeutic trial is nothing more than a very sophisticated method of eliminating practically all variables from a study.

Hippocrates' real contribution to medicine is that he was the first systematic taxonomist who wrote in a language that was understandable throughout much of the civilized world. Although there had been Pharaonic physician taxonomists among the Egyptians, the written language was so arcane that the information never became widespread. Hippocrates established the concept that diagnosis is the prerequisite to treatment.

There would be no argument with the OAM if it behaved like all other divisions of the NIH. The first step of the OAM should be to require any practitioner of an alternative therapy who claims to have a curative methodology to first demonstrate the ability to diagnose the disease he or she purports to treat. Remember, headache, back pain, sour stomach, leg pain, deafness and fever are not diseases. They are symptoms of disease. If the alternative practitio-

ner claims to have the ability to treat such diseases as diabetes, coronary atherosclerosis, multiple sclerosis and rheumatoid arthritis after having made an accurate diagnosis, the therapy should be described, demonstrated and then subjected to a standard double-blinded prospective trial, just the same as any other therapy. Furthermore, the alternative therapy should be reproducible and repeated by people who are in the medical mainstream – with the same results.

There may well be treatments that are worthwhile and adaptable to mainstream medicine if their efficacy can be scientifically demonstrated. After all, extract of foxglove, extract of yew, extract of cinchona bark, even morphine,

belladonna and aspirin may all be considered products of herbal medicine. Conversely, mainstream medicine should not sneer at the well-recognized value of placebo therapy and the cultural, psychosocial effects of witchcraft. As a matter of fact, many *bona fide* medical physicians do employ such mechanisms from time to time. Physicians should recognize them for what they are, however, and not attribute to them qualities they do not have.

As things stand, with the possible exception of some rain forest herbalist witch doctors, about which we know very little, none of the alternative disciplines have as yet been shown to have any ability to alter the progress of disease, injury and aging. If the

OAM can discover and prove scientifically that some alternative therapies can in fact attain such a goal, the tax dollars will be worthwhile. The real hazard of the so-called alternative therapies is that a person with a medically treatable disease may be ineffectively treated by the alternative practitioner until there is no medical possibility of reversing the disease process.

The other side of the coin is that if the OAM can positively demonstrate that an "alternative" method has no therapeutic value – *and publish the result* – perhaps the public will stop spending hundreds of millions of dollars on "treatments" that can accomplish nothing more than lying in a good hot tub can do. □

### Look-alike and sound-alike drug names

	<b>TERBINAFINE</b>	<b>TERFENADINE</b>
<b>Category:</b>	Antifungal agent	Antihistamine
<b>Brand name:</b>	Lamsil, Sandoz	Seldane, Marion Merrell Dow
<b>Generic name:</b>	Terbinafine HCl	Terfenadine
<b>Dosage forms:</b>	Cream	Tablets
	<b>ALTACE</b>	<b>ARTANE</b>
<b>Category:</b>	Antihypertensive	Antiparkinson agent
<b>Brand name:</b>	Altace, Hoechst Roussel/ Upjohn	Artane, Lederle
<b>Generic name:</b>	Ramipril	Trihexyphenidyl HCl
<b>Dosage forms:</b>	Capsules	Tablets, capsules, elixir

## ■ drug names

Benjamin Teplitsky, R. Ph.  
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □



## Unconventional medicine

George Lukemeyer, M.D.  
Indianapolis

The roots of the medical professions are deeply imbedded in history. Throughout recorded history, medicine, magic and religion have been intertwined. Primitive medicine can be traced back 10,000 years, and remnants of it are still present in remote areas of Africa, Asia, Australia and even some in Indian tribes and Eskimos in North America. To primitive peoples, the blend of religious rituals and magic in medicine is logical, and we can understand and respect their view. The modern physician can draw on this ancient heritage as long as the art of medicine is founded on the solid scientific base needed today in the care and treatment of patients.

In this issue of *Indiana Medicine*, Bob Carlson reports (page 256) on unconventional medicine in Indiana. He notes that in 1992, Congress established the Office of Alternative Medicine (OAM) in the National Institutes of Health (NIH) and comments on the goals of the OAM. Carlson briefly summarizes the widely publicized report in the Jan. 28, 1993, *New England Journal of Medicine* by David M. Eisenberg, M.D., et al titled "Unconventional Medicine in the United States-Prevalence, Costs and Patterns of Use." Carlson shares with *Indiana Medicine* the views of five Hoosier physicians and a Ph.D. professor about their involvement in alternative medicine. He follows with the comments from three "mainstream" Indiana physicians on the topic of unconventional medicine.

Elsewhere, in this issue of *Indiana Medicine*, (page 266), is an article by Stephen Barrett, M.D.,

"The Public Needs Protection from So-Called 'Alternatives,'" which is reprinted from *The Internist*, September 1994. George Manning, M.D., has a commentary "Alternative Care: What Is It? Does It Work?" on page 244. All of the above articles call attention to the establishment of the OAM in the NIH in 1992. This occurred largely as a result of the vigorous efforts of Sen. Tom Harkin (D-Iowa) who until recently was chairman of the powerful Senate Labor-HHS-Education Appropriations Subcommittee. Sen. Harkin, convinced that bee pollen capsules cured him of allergies, was a strong advocate of the OAM.

Joseph Jacobs, M.D., son of a Mohawk and Cherokee, was the first director of OAM. He grew up familiar with Native American Medicine and graduated from the Yale University School of Medicine. Dr. Jacobs resigned the directorship of OAM in September 1994.

The highly regarded journal *Science*, in its Sept. 30, 1994, issue, included the following comments in its News & Comment section, titled "The Politics of Alternative Medicine":

Devising a plan to study unconventional medicine, says one observer on Capitol Hill, is like "orchestrating a room full of cats ... or setting the agenda for a convention of anarchists." The field is a smorgasbord of therapies - ranging from meditation and prayer to acupuncture, homeopathy, shark-cartilage enemas for cancer, biofeedback, massage, dosing with bee pollen to stop allergies and many, many more. Each school is confident that its methods are the best. All distrust "the medical establishment" and most

aren't skilled in collecting data. Yet for the past three years, the National Institutes of Health (NIH) has been struggling - under orders from the U.S. Senate - to rope these diverse schools into a coherent research program.

The OAM has funded 43 projects totaling \$1,040,000 to individuals to investigate the clinical outcomes of unconventional medical therapies. Included among these are massage to stimulate AIDS patients' immune systems, hypnosis to speed bone healing, music therapy for patients with brain injury, dance for cystic fibrosis, macrobiotic diet to control cancer, yoga to control heroin addiction, biofeedback to treat pain and prayer to control drug abuse.

The age old search for the fountain of youth persists. People with chronic pain still seek magical cures for relief. When all else fails, the quest for miracles goes on unabated.

Physicians today, even though bedeviled by bewildering changes in the health care delivery system, are overwhelmed by the rapid advances in medical science and technology. All physicians should become familiar with and learn about the advances in molecular biology and molecular genetics. We can confidently forecast enormous progress in medicine's ability to prevent, diagnose, treat and cure some of mankind's most serious and common disorders such as atherosclerosis, breast cancer, diabetes, hypertension, osteoporosis, psychoses and other common diseases. Physicians of the next century may well regard today's level of medical science and technology as rudimentary.

Physicians now and in the future must bring the art and



current science of medicine to their patients. Doctors are obliged to become knowledgeable about and to fairly evaluate unconventional therapies and practitioners. Patients and the public must have access to reliable information in matters of health.

Wayne B. Jonas, M.D., recently was named director of the OAM at

the NIH and will assume the post in July. It is to be hoped that under his leadership the OAM will evaluate unconventional therapies in an open, unemotional, methodical and scientifically sound manner. Those therapies passing muster can readily be introduced into mainstream medicine. Those treatments proven ineffective or

dangerous should be banned. Providers of documented worthless therapies and unproven treatments, when withdrawing or withholding accepted mainstream therapies, should be held accountable and appropriately sanctioned. □

*Dr. Lukemeyer is chairman of the editorial board of Indiana Medicine.*

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# Managed care creates

Bob Carlson  
Indianapolis

Physicians practicing in a managed care environment sometimes find that what's best for the patient clashes with what management wants.

Marc A. Rodwin, J.D., Ph.D., has examined these conflicts of interests in his book *Medicine, Money and Morals: Physicians' Conflicts of Interest* (Oxford University Press, 1993) and in an article titled "Conflicts in Managed Care" in the March 2, 1995, issue of *The New England Journal of Medicine*.

Rodwin is associate professor of law and public policy at the School of Public and Environmental Affairs at Indiana University. He has published widely in law, medicine and policy journals on the relation between law, ethics and markets in the health and environmental fields. He has testified before Congress and state legislatures, served on government commissions and advisory boards and addressed professional societies.

Rodwin's next research project, entitled "Accountable Health Care: Competing Goals, Interests and Policy Approaches," is funded by a Robert Wood Johnson Foundation Investigator Award and explores different approaches to promoting accountable health care, particularly in managed care organizations. "I view conflicts of interest as a special kind of accountability problem," he says. "Managed care organizations present us with a fundamentally new situation, i.e., delivering medical care through a bureaucracy. The issues for the future, I think, are how do we make sure these organizations are accountable, determining to whom they should be accountable and

what means should be used to hold them accountable."

Before joining IU, Rodwin taught at Tufts and Brandeis universities. He also practiced law and consulted for clients including Blue Cross Blue Shield of Massachusetts, the World Wildlife Fund and the National Health Policy Forum.

In this interview with *Indiana Medicine*, Rodwin identifies the major conflicts of interest for physicians practicing in a managed care environment and proposes some solutions.

**Indiana Medicine: For those readers who did not see your article entitled "Conflicts in Managed Care" in *The New England Journal of Medicine* (March 2, 1995), can you briefly outline your basic concerns about these conflicts?**

**Rodwin:** Lots of people in managed care organizations assume that the interests of patients, doctors and managed care organizations are always consistent and mutually reinforcing. That's often, but not always, the case. The interests of these groups can diverge. There are three basic conflicts that I'd like to discuss.

The first is that managed care organizations give doctors an incentive to be frugal in their use of services. Doctors tend to be compensated more if they order fewer tests, procedures and hospitalizations and make fewer referrals. They call this risk-sharing, and there are many ways to do this. However, whether it's based on payment of a bonus, or a decrease in income, the effect I'm worried about is the same, and that is that a physician will have





# conflicts of interest

an incentive to skimp on providing services.

The second type of conflict in managed care arises from the first. The legal doctrine of informed consent requires that doctors explain to patients the choices available, the risks and benefits of proposed treatment and any alternatives. They must also obtain the patient's consent before performing any medical procedure. Under traditional fee-for-service practice, the patient has a broad range of choices, but managed care quite explicitly structures the level of medical care to reduce patient choice and to control the options available. Because doctors have this financial incentive to reduce services, that may affect their perceptions about what's necessary or what choices are desirable. Therefore, they may be offering limited choices to patients or talking about choices that steer the patient to less costly treatments.

The third major problem in managed care has to do with case managers. Many managed care organizations have what they call a case manager to help coordinate services that patients get. Usually, for high-cost cases, case managers will work with physicians and providers to try to find less costly ways of providing services. Often, they'll provide more services, or services not covered by the policy, because ultimately it's less costly. For example, many managed care firms will allow their case managers to provide home treatment or home care or even remodeling of the home to some extent so that the patient can be treated there if they need a wheelchair or something like that. So there is the potential for great benefits for

patients.

But case managers are also in a position to limit services in terms of choosing what will be reimbursed or by overriding the decisions of doctors. Case managers are employed by and work for the managed care firms and ultimately they have their employer's interests at heart. If they don't, they may not be employed for long.

One way to deal with this is and make the case manager more responsive to the patient is to give the patient some choice over who these case managers are, so that

***Under traditional fee-for-service practice, the patient has a broad range of choices, but managed care quite explicitly structures the level of medical care to reduce patient choice and to control the options available.***

the case manager would be working for patients and their interests rather than trying to save money for the managed care firm. If independent professional case managers were chosen by both the managed care firm and the patient, then both would have to agree that they were working in their interests. We have a procedure like this in arbitration where both sides

have to agree. Often each side will choose one arbitrator from a panel, and the two arbitrators will choose a third. Over time, arbitrators develop a reputation as to whether they are fair, and those that are known to be always pro-labor or pro-management will often not be picked. Case managers currently lack neutral standards or a code of ethics.

**Indiana Medicine: The focus of managed care appears to be on providers, hospitals and insurers. Is there too much emphasis on the economics of managed care and not enough emphasis on patient care?**

**Rodwin:** What managed care does is provide medicine with the benefits of a large organization, i.e., supervision of physicians, coordination of services, economies of scale in purchasing. The solo practitioner might be first rate but simply doesn't have the resources on hand that a doctor in a large group practice does, with colleagues to consult, with back-up and support, with expertise and the like. So there really isn't a direct conflict between necessary patient care and a large organization. Those two can be consistent.

If the managed care organization does the managing well, then you're going to get substantial benefits from the expertise and knowledge and the information systems. Frankly, there are things that we can do to improve quality of care in a managed care organization that we couldn't do in the past and that individual physicians can't do alone. The problem is not that managed care organizations overemphasize the economics or organization. The problem is



figuring out to whom managed care organizations should be responsible. As of now, their primary fiscal and legal responsibility is to the owners, the shareholders and to some independent quality reviewers. There's much less of a role for consumers or patients or for physician involvement. Just as in other areas of commerce, businesses can be run poorly or well. Managed care organizations can do things that are helpful for consumers or they can engage in consumer fraud.

Let me put it this way. If the managed care organization is doing management in a good way, they will be taking care of patient care. They will be setting up quality assurance systems. They will be developing physicians' clinical skills and continuing education. They will be trying to make sure that patients are satisfied and monitoring grievances to identify patterns of problems. Management can do all sorts of things that help patient care. Whether organizations do these things or not depends on how they are managed.

For example, you can give physicians financial incentives to provide good quality of care, at least in theory. It's very hard to measure quality of care, and a lot of organizations pay lip service rather than do it. But it can be done. If the economic incentives are channeled in the right way, it will actually promote patient care.

**Indiana Medicine: How does managed care affect what physicians tell their patients about treatment options?**

**Rodwin:** Managed care affects what physicians tell patients about

treatment options in two or three ways. First, a whole range of options that would exist in fee-for-service practice are excluded. Managed care organizations decide what services will be provided and which providers will be on the list to provide them, so some choices that you can get in fee-for-service are not options. Patients simply cannot choose any physician or hospital, as you can in an indemnity insurance policy. Therefore, physicians either have to tell patients that you can't get this service, or you have to get it through our providers. Alternatively, physicians can tell patients that they can perhaps choose another provider or get other services, but we're not going to pay for it.

The second way that managed care is affecting what physicians tell their patients is indirect. Doctors are being paid in ways that will promote the goals of the organization. They are given incentives for using services frugally and that may affect their judgment about what is necessary or the way they think about medical choices. The influence may be unconscious. Doctors may downplay certain options or skip over them because they now think of them as futile or unnecessary. We don't have good data about the extent to which this is happening, but it is clearly the aim of the managed care organization to manage the patient and manage the doctor, and that means managing what information is given and what choices are available.

**Indiana Medicine: Managed care is designed to cut costs. How can physicians provide a meaningful choice of treatment options for**

**patients when costs are such a concern?**

**Rodwin:** Physicians do have a degree of autonomy. They are always relied on to make the final medical judgment. Physicians can provide meaningful choice by using their best judgment to say what is required or necessary or good medicine. This may involve being an advocate for patients in a way that physicians are not used to. It may mean actually engaging in a process of appealing decisions that managed care organizations make to limit treatment. I'm thinking of the *Wickline vs. California* case particularly, where the doctor suggested a certain length of hospital stay and the managed care organization, MediCal in this case, in California, thought that it was excessive and recommended two days rather than five. The doctor followed the recommendation, the patient went home and developed gangrene in the leg, and it had to be amputated. The organization and the doctor were sued by the patient, and the court held that the MediCal program was not liable because the doctor had not exhausted his administrative appeal in the organization. After the managed care organization had recommended that the patient should go home, the doctor had a right – and an obligation – to appeal the denial of extra hospital days if he felt the judgment was wrong.

In short, the doctor is being given the burden of proving that what they suggest is necessary and this, unfortunately, is what doctors are going to have to do to make sure that there's meaningful choice for patients. They're going to have to articulate their medical judg-

ment and provide justification for it and deal with bureaucratic structures in the organization.

**Indiana Medicine:** In view of what you have been saying about how difficult that is to do in a managed care environment, what with financial incentives that may nudge doctors in the other direction and case managers that may overrule a physician's decision, what are the external incentives for a physician in a managed care organization to be the patient advocate that you have just described?

**Rodwin:** I'd like to distinguish between financial incentives and other incentives for doctors to be the advocates of the patient. Physicians have a long tradition of medical ethics, of acting in the interest of the patient, and that has formed a good deal of their behavior. I hope that sense of professional commitment will be preserved, and I hope that there is still an incentive to do the right thing and to care for the patient. Unfortunately, the financial incentives to do so are not always there. It's not that there's an incentive to do the wrong thing, it's just that the financial incentive is to be as frugal as possible.

**Indiana Medicine:** In your book and in your articles you make the argument that, in spite of professional ethics, in spite of physicians' commitment to providing the very best medical care that they know how, we have a problem with conflicts of interest. That being the case, what counter-incentives can you point to that would at least balance the incentives that you've been

pointing to as generally negative in their results?

**Rodwin:** I don't think there are currently strong financial incentives that encourage doctors to act in the interest of the patient. Some people have said that there is an incentive not to be sued for malpractice. If doctors are acting in ways that are egregious to the interest of the patient, they may be sued, which will be noticed, and managed care organizations may not renew physician contracts. There's a strong financial incentive

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*I think we can develop other means to control health care costs while giving physicians incentives that do not bias individual clinical choices.*”

not to do that because these doctors will not have their contracts renewed or will lose malpractice suits. But that's a very weak and indirect incentive. It doesn't deal with the subtle issues. What I think we need to do is develop counter-incentives for doctors to act in the interest of patients. Let me name two or three things that we could do.

First, I'm very skeptical about risk-sharing in a managed care organization. I don't think it's necessary. Although about 85% of HMOs have some kind of risk-sharing arrangement with doctors,

it's a relatively recent phenomenon. The older-line group-model HMOs that were first formed didn't have risk-sharing arrangements.

I think we can develop other means to control health care costs while giving physicians incentives that do not bias individual clinical choices. I think that a salary would be one way of paying doctors so that they don't have a direct incentive to provide either more or fewer services. What worries me now with risk sharing is that doctors have an incentive each time they provide or don't provide a service, and that makes them think too much about individual clinical choices in terms of their own financial interest. A salary wouldn't bias clinical judgment in the same way. There would still be some indirect financial incentives. The doctor might be worried about losing his or her job if the managed care organization goes broke, but it wouldn't be tied to individual clinical choices. So one thing we can do is eliminate risk-sharing, but I don't know if that's politically feasible.

A second thing we could do is limit the amount of risk-sharing to make sure that it's only a small part of the compensation physicians receive and therefore less of an incentive to reduce services. There are some federal regulations for Medicare that limit risk-sharing, but they're not very strict. They basically allow the status quo.

A third thing one might do is actually develop incentives for promoting quality of care. That would be a good kind of financial incentive. The problem, of course, is that it's very hard to measure quality of care, to develop incen-



tive and to link the two together.

My other suggestions don't have to do directly with financial incentives for physicians but with promoting the authority or voice of independent parties or consumers in the organization. Right now, managed care organizations are pulled in different directions, but very strongly to the interest of shareholders if they are for-profit or to other parties if it's a non-profit HMO.

The one party that is really left out of this is the patient. Physicians are beginning to organize as groups and bargain with managed care organizations to make sure that they have some input, and although they act in the interest of the patients, they are also trying to promote their own interests. The payers are organized and have clout. The suppliers have clout. But patients tend to go into managed care organizations as individuals or through their employers, and once they've entered, they don't seem to have anyone to represent them in an organized way. The ability to simply leave an organization is not a very powerful tool, particularly if you're a patient who's going to cost the organization a lot of money. Why should the managed care organization worry about someone leaving if they happen to need chronic care? What I'm worried about is that the organization is not going to be highly responsive to individual patients leaving if those patients are going to be expensive. They may even encourage those patients to leave. That's called adverse selection and we've had it in insurance outside the managed care organizations for years.

What I'm suggesting is that

we shouldn't just tell consumers that they should leave managed care organizations and join another if they are dissatisfied with service. We should allow them to have some kind of control over what kind of policies the organization has. If people who suffer from one particular illness are not getting good services from the managed care organization, there should be some way for them to publicize their grievances or, through representation, to change the organizational practices.

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*Doctors should promote the idea of independent reviewers and clinical guidelines, and that may, in the long run, help make the organization accountable to some kind of external neutral standards.*  
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**Indiana Medicine: Many physicians are opposed to managed care because of the conflicts you've been discussing. You touched earlier on what a physician can do if the goals of his or her managed care organization are in conflict with what's best for a particular patient. Can you discuss this issue in more detail?**

**Rodwin:** If the doctor finds a conflict between what's in the best interest of the patient and what the

organization wants to do, there really are two different approaches one can take, dealing with this either on the level of an individual patient, or dealing with the problem as a matter of general policy in the organization.

When the organization is doing something that is not in the interest of the patient, doctors can and should advocate for their patients and explain what they think is good medicine and why what the organization is suggesting is not good medicine. If they build a strong case, a lot of organizations are going to be responsive. Managed care organizations are also worried about liability.

The harder case is when there is a general policy problem affecting many patients. What if the physician doesn't have the patient right in front of them where they can point to a situation that is not in the interest of the patient? What if the problem is that the organization is badly run or that their policies are generally neglectful? That's a lot harder for individual physicians to deal with because they are really being asked to change a bureaucracy. That can only be dealt with by doctors as a group. Doctors are going to have to get together and organize in some way to promote standards. I don't think it can happen just at the level of their advocating what they think is right because there needs to be reference to some independent standard. Doctors should promote the idea of independent reviewers and clinical guidelines, and that may, in the long run, help make the organization accountable to some kind of external neutral standards. Right now, we don't have such guidelines for all but a few procedures,



and because of that, it's been much harder for doctors to object to policies that promote bad medical care.

**Indiana Medicine: What can physicians do to assure that they have the voice that you have been describing in managing the health care delivery system?**

**Rodwin:** Doctors are beginning to form group associations and through their associations, bargain with managed care organizations. When a large group of physicians comes to an organization, they have a certain amount of clout. They have clout because they have loyal patients. If, as in California, 500 or more physicians form a group practice and get together and say here is what we are suggesting needs to be done in terms of our joining your organization, the organization will be more likely to listen to them than to an individual physician.

My concern is that often these groups have organized primarily to protect the financial interests of the physicians. They should be getting together to think about what is good medicine. If physicians are concerned about providing good medical care, I would suggest that they advocate for some kind of patient organization as well. I don't think we can go back to the time when whatever doctors say will be assumed to be in the best interest of the patients. One of the reasons we have managed care now is that there have been 20 to 30 years of well documented evidence of excessive and unnecessary utilization of services and of services provided in ways that were inefficient. In a sense, managed care organizations

were developed to oversee the judgments of physicians. What needs to be done now is to promote some kind of independent standards developed by physician experts who don't have an incentive in what services should be provided, and to promote patient voice within managed care organizations.

**Indiana Medicine: You have said that so-called "old line" HMOs did improve the quality of health care. What are "old-line" HMOs and how do they differ from the newer managed care organizations?**

**Rodwin:** What I've said is that the older HMOs, by which I mean the group model HMOs that had a closed panel of physicians, typically on salary, and with the organization owning the medical facilities, like Kaiser in California, Group Health, Puget Sound in Washington State and Harvard Community Health Plan in Massachusetts, the evidence showed that they tended to provide good quality care, perhaps even better than fee-for-service in some cases, and that they did this generally by reducing unnecessary hospitalizations, up to about 20% reduced hospitalizations, and by providing more primary care. It was much easier to generalize about these HMOs because there was a smaller number of them. Today, it is much harder to generalize about managed care and HMOs because there are so many different variations on how to manage these organizations, so many models, and so many different ways of compensating physicians. The market is changing so rapidly that you could almost say that we

know less about HMOs than we did 20 years ago. The old generalizations don't stand up any more.

How are the newer HMOs different? One of the newer trends is the growth of preferred provider organizations where there is an incentive for the patient to use physicians in the closed panel list but also an option to choose any physician. If patients go outside the panel and choose any provider that they want, they pay more in copayments and deductibles.

What we know is that the older HMOs provided very good quality care and, in some cases, were better than fee-for-service. It's harder to make generalizations about managed care now simply because there are so many variations. If you've seen how one managed care organization operates, there are not a lot of inferences you can make about another one because they will have a different management and structure and incentives. They also have a much shorter track record.

**Indiana Medicine: As managed care expands, how will the quality of health care be affected?**

**Rodwin:** I don't think one can make glib generalizations about how the quality of care will be affected as managed care expands because a lot is going to depend on how these organizations are structured and what the incentives are. There is a potential to increase access. There's also the potential for some reduction in quality if the organization is not managed well, but it really depends on how they are run, and I would be skeptical of anyone saying categorically that it's always going to be better or worse.

Managed care creates new options for promoting the quality of care. It offers the potential for quality controls that you cannot get in fee-for-service practice. It allows ways to monitor what physicians are doing, what their outcomes are, and that typically doesn't happen in fee-for-service. So if your fee-for-service practice is giving less than average quality of care, you might be much better off in a managed care organization. On the other hand, if you're getting the cream of the crop in fee-for-service practice, you might be no better off in managed care, and if the managed care organization is poorly run, you might be worse off.

Managed care is a term for a wide range of things, and it's very hard to generalize about it. It's almost like asking if we are going to get better quality service now that we have supermarkets instead of small grocers. Large grocery chains have all sorts of potential that a small grocery store doesn't

have. You can purchase large contracts, and maybe you can get fruit from far away places. You'll have someone taking surveys of consumers, so you might get all sorts of better quality for shoppers because they can do things that a mom and pop grocery store couldn't. That doesn't mean every large grocery store is going to be a good one. You can have a large grocery chain that is going to have bad produce or is badly run or carries shoddy goods. A lot will depend on the competition in the area and how well the supermarket is managed. The small grocer can either be one that caters to people who have lots of money and carries all sorts of exotic fruit and good services, or it could be a place that doesn't provide much variety and doesn't cater to the customer as much because there's not another store for many miles. Similarly, there's simply not going to be one situation for all managed care organizations or for all fee-for-service practices.

**Indiana Medicine: What message would you like to leave with physicians about conflicts of interest in managed care?**

**Rodwin:** Managed care has conflicts of interest and they need to be addressed. But the way to address them is by changing the way managed care organizations are organized and the way physicians are paid rather than trying to avoid managed care. There are equally great conflicts in fee-for-service practice. What we need is doctors exercising their independent judgment and standing up for what they think is good medical care and the best interest of the patients. The best way to do that is to make sure the doctor doesn't have a direct financial interest in promoting one kind of clinical choice over another unless it is directly linked to quality of care. □

*Bob Carlson is a health care writer based in Indianapolis.*



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# Unconventional medicine in Indiana

Bob Carlson  
Indianapolis

Acupuncture, chiropractic, homeopathy, massage and meditation are not usually prescribed by mainstream physicians in the United States. Still, millions of Americans are using these and scores of other unconventional therapies – and paying billions of dollars out of pocket for them.

According to a survey published in *The New England Journal of Medicine*, chances are that at least one-third of your patients with anxiety, obesity, back problems, depression or chronic pain are dabbling in some form of unconventional medicine. And almost three-fourths of them haven't told you they're doing so.

## What it's not

By one count, there are some 200 fields of unconventional medicine, sometimes called alternative medicine. So what alternative medicine is *not* may make a better working definition than trying to pin down what's included. By definition, then, alternative, unconventional or unorthodox medicine is medicine *not* currently taught widely at U.S. medical schools or generally available at accredited U.S. hospitals.

Alternative unconventional therapies can be arranged into four broad categories such as historical medicine (Chinese, Native Ameri-

can, *Ayur-Vedic*, etc.); "body-work" (massage, Rolfing, acupressure, etc.); psychological or psychospiritual medicine (guided imagery, meditation, neuro-linguistic programming, etc.); and a fourth catch-all category that includes an eclectic mix of other therapies such as chiropractic, natural medicine, chelation therapy, etc.

Others group alternative medicine into physical therapies (natural healing, herbal medicine, homeopathy, manipulative therapies, oriental therapies, exercise/movement therapies, and

increasing attention from the media.

In 1993, the PBS series "Healing and the Mind" with Bill Moyers captured twice the usual audience, and the book became a best seller. "60 Minutes" has done segments on alternative therapies. Current periodicals from *Time* to *Forbes* to *Smithsonian* are replete with articles about alternative medicine. Authors such as Bernie Siegel, M.D., (*Love, Medicine and Miracles*; *How to Never Grow Old*; *Peace, Love and Healing*), Dean Ornish, M.D., (*Dr. Dean Ornish's*

*Program for Reversing Heart Disease*; *Stress, Diet and Your Heart*) and Deepak Chopra, M.D., (*Ageless Body*, *Timeless Mind*; *Perfect Health*; *Quantum Healing Workshop*) have

passed each other on *The New York Times* Book Review Best Sellers list.

In 1992, Congress established the Office of Alternative Medicine (OAM) in the National Institutes of Health (NIH). The purpose of the OAM is to sponsor clinical research studies of unconventional medical therapies and integrate proven and successful therapies into mainstream medicine.

## Unconventional medicine in Indiana

Lots of Americans are using alternative therapies and Hoosiers are no exception. Among those who provide these therapies, nationally and in Indiana, are a surprising number of physicians.

Here is what some Indiana

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***Although it is difficult to make generalizations about more than 200 unconventional therapies, almost all tend to be used for chronic rather than acute conditions.***

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sensory therapies); psychological therapies (psychotherapies, behaviorism, humanistic psychology and transpersonal psychology); paranormal therapies (healing shrines, exorcism, radionics, psychic surgery, etc.); and paranormal diagnosis (Kirlian photography, iridology, biorhythms, etc.).

Although it is difficult to make generalizations about more than 200 unconventional therapies, almost all tend to be used for chronic rather than acute conditions.

## Unconventional medicine in the United States

During the last five years, unconventional medicine has received

physicians and a professor who is not a physician shared with *Indiana Medicine* about their involvement in alternative medicine.

#### **Gary Moore, M.D., Indianapolis**

"I truly believe that if I had not done something of an alternative nature, I would have been relegated to a world of tranquilizers and muscle relaxants," says Gary Moore, M.D.

Dr. Moore was an anesthesiologist at Humana (now Indianapolis Women's) Hospital when he was diagnosed with multiple sclerosis (MS) in February 1990. After two weeks of taking the muscle relaxants, tranquilizers, CNS depressants and bladder tonic medications prescribed by his neurologist, he says "I felt like I was in a chemical straitjacket. I could not really start any worthwhile exercise programs because I was so tired from the medication." So he threw away his medications and started looking for something else.

#### **From Humana to holistic**

One of his first stops was a health food store in Indianapolis, where the owner suggested several books about MS and a nutritional program including antioxidants, vitamin supplements, herbs and a balanced diet with restrictions on preservatives, gluten, refined sugar and dairy products.

Did Dr. Moore feel strange walking into a health food store?

"Sure I did. I was an allopathic physician with years of training. I felt very strange. But that didn't last very long. There were things that were much more important, like getting better and hopefully pursuing my life goal of medicine

again." He also sought counseling and began an exercise program. "It was a slow, gradual process, but lo and behold, I started feeling better," he recalls.

The owner of the health food store, a retired Ph.D. in biochemistry, also recommended an oral medication, Calcium EAP (ethanolamine phosphate), developed for MS patients by Dr. Hans Nieper, an internist, cardiologist, oncologist and vacuum field physicist in Hanover, Germany. The FDA subsequently banned Calcium EAP in the United States. In late 1991, Dr. Moore went to Germany and put himself under Dr. Nieper's care.

Calcium EAP is the treatment of choice for MS in Germany. When Dr. Moore was there, Dr. Nieper was a witness in a malpractice trial involving a physician who did not prescribe Calcium EAP for a patient whose symptoms were compatible with MS.

"When I started his EAP treatments," recalls Dr. Moore, "I was staying in Langenhagen, a suburb of Hanover. I would walk to the train station in Langenhagen, take the train to Hanover and then walk from the *Hauptbahnhof* (main train station) to Dr. Nieper's office, which was about a mile and a half. The first day, that walk almost killed me. I had to stop about three or four times. Toward the end of the second week, I was literally running back and forth."

Today, Dr. Moore's daily routine includes exercise. He bikes outdoors from 5 to 15 miles and swims a half mile on alternate days.

He opened a general holistic practice in Indianapolis a year ago.

"Holistic medicine means

different things to different people," he explains. "My interpretation is that there is more to healing than allopathic medicine, although I certainly do not advocate abandoning allopathic medicine by any means. Holistic medicine includes mental medicine, energy medicine and nutritional medicine, with allopathic medicine as the fourth main category."

#### **C.S. Archangel, M.D., Jeffersonville**

"Doctors or pills don't cure people. Patients cure themselves, with God's help. It's not the acupuncture or the needle that cures," says C.S. Archangel, M.D. "It is only an instrument to mobilize the body's defense mechanisms."

Dr. Archangel practices general psychiatry in Jeffersonville. In 1982, he attended an acupuncture seminar, taught by a physician, in Las Vegas. He completed that session and the advanced course, and then repeated the advanced course. In subsequent years, Dr. Archangel has taken numerous courses in the United States and in Canada from Chinese and European acupuncturists. After returning from Las Vegas and completing more course work, he ordered his first electronic acupuncture instrument and first offered acupuncture to his patients in January 1984.

"We use an electronic instrument to measure the status of the energy systems in the body at designated test points," explains Dr. Archangel. "This is comparable to the pulse diagnosis done by a physician in classical Chinese medicine. With the needles, we pass a subtle electrical current through specific meridians where



the readings are either too high or too low."

Using acupuncture, he has successfully treated headache, including migraine, Sjögren's syndrome, low back pain (even after laminectomy or discectomy), and sympathetic dystrophies. Although he has anecdotal evidence of acupuncture's effectiveness against maladies like influenza, Dr. Archangel says he doesn't have any research studies to back that up. He advocates acupuncture only for chronic pain disorders. "No pills, no shots," he emphasizes.

**Wesley B. Wong, M.D.,  
Indianapolis**

For many of the chronic pain

patients he sees in his neurology practice at St. Vincent Hospital in Indianapolis, Wesley B. Wong, M.D., finds acupuncture a useful complement to pills and shots. "One of the main complaints that people have when they come to see me is that they're on so many pain medicines that even though their pain is controlled, they feel too drowsy to function," says Dr. Wong. "One useful aspect of medical acupuncture is that we can sometimes reduce those pain medicines. It gives them another option to control pain without feeling the side effects of the medications."

Dr. Wong received his medical degree from the University of Oklahoma, completed his resi-

dency in neurology at the Indiana University Medical Center and is currently the medical director of the John Marten Center for Complementary Medicine and Pain Management at St. Vincent Hospital.

He has always had an interest in acupuncture, probably, Dr. Wong says, because of his Chinese-American background. Patient demand also played a part in his decision to add acupuncture to his practice. "I am trained in electrophysiological medicine, and when I do EMGs, patients routinely ask me, 'Is this acupuncture? Is this like acupuncture? Do you do acupuncture?'"

In 1992, he enrolled in a certified medical acupuncture course at UCLA that consisted of lectures in California followed by home study with videotapes. After passing an examination, he went to Washington, D.C., for further hands-on clinical training. Dr. Wong is a member of the American Academy of Medical Acupuncture and emphasizes that he uses only disposable, sterile needles.

"I find acupuncture works surprisingly well in some patients but less optimal in others," says Dr. Wong. His practice in pain management includes treating neck pain, headaches, back pain, peripheral neuropathies, cancer pain and post-radiation pain. He emphasizes that he uses acupuncture as a complementary method and not as a sole approach to treatment. Dr. Wong sees acupuncture as another treatment option, depending on the patient's needs.

"I think the key word is balance," says Dr. Wong. "I try to balance very carefully what I do as a physician versus what I do for

**Wesley Wong,  
M.D., of India-  
napolis uses  
acupuncture as a  
complementary  
treatment for  
pain manage-  
ment.**





pain management with medical acupuncture. I believe one must first undergo a basic medical examination, testing and diagnosis, and then use complementary techniques as a supplement to standard methods of pain management."

**John C. Peterson, M.D., Muncie** "I guess I really don't consider myself too alternative," says John C. Peterson, M.D. "I'm board certified in family practice, and I maintain my certification. I'm an assistant clinical professor at IU, so I teach medical students and residents all the traditional things." He also serves on the Delaware County Board of Health.

Dr. Peterson has integrated *Ayur-Veda*, the medical science of ancient India, with his practice of mainstream Western medicine.

How does a system that's thousands of years old mesh with modern medicine?

"They're totally compatible," says Dr. Peterson. "I always explore in some depth what my patients have been through, ruling out things that could be approached in a conventional way. I make sure all cancers have been ruled out and that adequate conventional treatments have been tried. I look at ayurvedic medicine as a complement to include or as an alternative to go to when other things don't work. Some people of course want to try it as their first choice alternative, and I'm OK with that as long as I feel like we've covered all the bases."

Dr. Peterson's interest in *Ayur-Veda* goes back to his days at the University of Iowa College of Medicine in the early 1970s, when he learned the Transcendental Meditation technique. "I haven't



**John Peterson, M.D., of Muncie uses pulse diagnosis to help find the root cause of medical problems.**

missed meditation twice a day for the last 23 years. It's a part of my life. It got me through medical school and my residency program with my mind at least partly intact," he laughs.

#### **Touring with the *vaidyas***

In the 1980s, when *vaidyas* (Indian doctors trained in *Ayur-Veda*) came to the United States on lecture tours, they were required to have licensed American physicians in attendance. Dr. Peterson was asked to sit in. "As they'd come through the Midwest, I'd meet up with them, and we'd lecture and tour together. It was a tremendous experience. When I first sat in, I was just curious. When I saw how

powerful *Ayur-Veda* was, I wanted to learn it."

*Ayur-Veda* is a Sanskrit word that means science or knowledge (*veda*) of life (*ayu*). According to Dr. Peterson, the basic principle in ayurvedic medicine is to find the root cause of medical problems. This is done by pulse diagnosis and body typing. The three *doshas*, or principles that govern different aspects of the mind and body, are *vata*, *pitta* and *kapha*. Body type, personality and predisposition to diseases are determined by the relative proportions of these *doshas*, with one *dosha* usually primary. "All medicines and treatment can be totally individualized according to these body

types," says Dr. Peterson. "The tendencies for diseases can also be determined from that. You can almost predict the kinds of problems a particular body type is going to get."

By feeling the deep pulse with the second, third and fourth fingers, it is possible to confirm the primary body type, i.e., one's nature or *prakriti*. The superficial pulse reveals imbalances in the three *doshas*. These imbalances, or *vikriti*, says Dr. Peterson, are usually the seeds of a disease. Each *dosha* is subdivided into five *subdoshas*, which correspond to specific organ systems or functions. *Ama*, or impurities in the body tissues that obstruct the flow of blood and nutrients, can be detected in the mid-pulse.

"Pulse diagnosis is very systematic and gives a tremendous amount of information," says Dr. Peterson. "We'll set up a program first to remove the impurities, the *ama*, then bring balance to the *doshas* and hopefully return the patient to his or her nature, their *prakriti*." *Ayur-Vedic* treatments can involve all the senses, according to Dr. Peterson, and include music, meditation, stretching, physical therapy, massage, color therapy, aromatherapy, herbs and diet and even the architecture of a patient's residence.

Wednesdays and Saturdays in Dr. Peterson's practice are set aside for patients who come from all over the Midwest, and as far away as Florida, for *Ayur-Vedic* consultations. On those days, says Dr. Peterson, who is also medical director of the Maharishi Ayurveda Health Center in Indianapolis, "we're as busy as we possibly could want to be. The trend is definitely going to *Ayur-*

*Veda*."

What about patients who come in to see Dr. Peterson, family physician?

"Pulse diagnosis is the first thing I do in the office. It focuses my attention on the patient and gives me a lot of useful diagnostic information. I don't really talk much about *Ayur-Veda* if I feel that someone would be uncomfortable with foreign words and concepts. Of course when I ask a patient questions about really specific symptoms that show up in her pulse before she's said a word, she'll often get curious and want to learn more. Several times a day I may make simple *Ayur-Vedic* recommendations and occasionally I refer a regular patient to my *Ayur-Vedic* practice."

**Lois K. Lambrecht, M.D.,  
Bloomington**

"I may have an acupuncturist or a homeopathic physician working with me. I refer openly to chiropractors. I have very particular ones that I use that I know are excellent in their approach. These are really very benign modalities. Most of them are extremely well-documented," asserts Lois K. Lambrecht, M.D.

Dr. Lambrecht, a graduate of the IU School of Medicine, describes her internal medicine and primary care practice in Bloomington as her own personal experiment. She opened her Bloomington practice in August 1993 after seven years as a primary care physician with University Health Care and 10 years on the faculty at IU Medical Center in Indianapolis.

How is her experiment working?

"It's doing very well," re-

sponds Dr. Lambrecht. "It has been a lot of fun and people are getting better." All kinds of people, she says, even people who don't go to doctors. People come to her, she believes, for several reasons. She tries to help them sort through what is going on with them, not only physically, but in terms of stress, anxiety, depression or underlying family patterns, for example, that may be contributing to their illness.

"Psychosomatic medicine is something that we all participate in on a regular basis as physicians," says Dr. Lambrecht. "But I really see a very strong correlation between the way people think and feel and the way their bodies function. So I take a lot of time with them. What they tell me is as important as whatever physical exam I do. We don't look at disease as necessarily a negative thing, we see it as a learning experience, an opportunity for growth rather than something we have to immediately fix. If somebody comes in with 10 years of fatigue, you are not going to take that away from them overnight, but maybe you can help them understand why it is still with them and what it has taught them and what they could potentially do to improve their health and their life."

She helps people understand how their bodies work, says Dr. Lambrecht, and teaches them to be intuitive with their bodies and to help themselves more. "I see such a lack of understanding and comfort with what is happening in people's lives with their bodies. I see it every day, all day long, with people who are highly intelligent. My patients are primarily responsible for their own health, and I am



a partner with them in the process of understanding what is happening with their bodies. When somebody has a lower GI series in my clinic, they know what is going on inside them. That's different than going to a doctor and saying, 'I feel this way. Fix me.'"

### **Other forms of healing**

When necessary, she enlists the expertise of unconventional medical practitioners. "I practice traditional allopathic medicine. I am a staunch and extremely loyal supporter of traditional medicine because I know it works. But I didn't go into medicine with the idea that it had all the answers. I had already experienced many other forms of healing before I ever went into medicine. There are some other things out there that we should be using and I want to be a part of helping our profession grow so that we can do more for our patients."

Dr. Lambrecht deplores the confusion, paranoia and distrust – among physicians as well as the lay public – about alternative medicine and is a strong proponent of continued research. "We are not taught about these things in medical school. Trying to sort through what is real and what isn't real is a highly complex thing. If there are articles to be written, then we should help write them. I think it is our responsibility as medical doctors and complementary practitioners to help do the research."

### **Vimal Patel, Ph.D., Indianapolis**

"My expertise is in genetic diseases, particularly diseases called lysosomal diseases," explains Vimal Patel, Ph.D., associate professor of pathology and laboratory medicine at the IU School of Medicine. "I was director for 15 years of a neurochemistry laboratory, which I established. I developed many tests to conduct diagnoses for these rare neurodegenerative diseases." Seven years ago, he gave that up and began research into alternative medical systems, specifically the *Ayur-Vedic* system of medicine.

The observations that Dr. Patel says motivated him to redirect his

*rasayana* would have an influence on the process of metastases in mice.<sup>3</sup> "Sure enough, we were able to show a 65% reduction in both the size and number of metastatic nodules," says Dr. Patel. "That really changed my attitude completely. So I was willing to try a few other things to see whether biologically these things they've been claiming for thousands of years have some meaning."

Since 1989, Dr. Patel has been collaborating in animal and human studies in the United States and in India on the effect of *Ayur-Vedic* treatments on chronic ailments such as arthritis, chronic fatigue syndrome, seasonal allergic

rhinitis, asthma and hypertension. He says these studies are extremely encouraging but emphasizes that findings thus far are preliminary. One study on the use of a *rasayana* traditionally used for memory enhance-

ment, relieving anxiety and managing depression and behavioral disorders may have implications for the treatment of memory dysfunction, especially Alzheimer's disease.

### **Indiana Institute for Complementary Medicine**

The establishment of the Office of Alternative Medicine by the NIH in 1992 gave him and other alternative medicine researchers a tremendous boost, says Dr. Patel. Together with other researchers, Dr. Patel prepared to submit a proposal to the NIH in 1993 to develop an exploratory center in alternative medicine. The IU

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***We thought we should combine our expertise in Indianapolis and in Indiana and begin to study complementary therapy. We need to weed out the good from the bad, says Dr. Patel.***

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research interest resulted from his collaboration in experiments with herbal food supplements and natural tonics, or *rasayanas* (pronounced raSIGHnas), used in ayurvedic medicine. Referring to an experiment conducted in 1987 to determine the influence of an herbal *rasayana* on the immune system of rats, Dr. Patel recalls, "It had a tremendous effect on cell-mediated immunity. We were really very pleasantly surprised. In fact, I didn't believe it. I said maybe this is a fluke."<sup>2</sup>

Since the immune system is intimately involved in cancer, the researchers decided to follow up with a study to see if the same



School of Medicine declined to participate in that proposal. One outgrowth of that grant application was the formation in June 1994 of the Indiana Institute for Complementary Medicine (IICM), an independent, non-profit corporation.

"When I was doing this proposal, I came in contact with hundreds of people who were interested in developing an institute that will address the research issues for these kinds of therapies," recalls Dr. Patel, who is president of the IICM board of directors. "We thought we should combine our expertise in Indianapolis and in Indiana and begin to study complementary therapy. We need to weed out the good from the bad. If it's valid, then we can help incorporate it in the system. If it's not validated, we discard it."

The goals of the IICM are conducting research through a proposed Center for Complementary Medicine Research; educating non-physician alternative practitioners as well as physicians; and providing a practice environment where the work of alternative practitioners can be studied.

"We want to put complementary medicine on the map in Indiana," says Dr. Patel.

"Complementary Medicine: Its Value and Its Validation," the first in a series of seminars sponsored by the IICM, was held March 17-18 in Indianapolis. Dr. Patel was the director of the seminar. Dr. Patel also recently was chairman of a program titled "Modern Scientific Methodologies and Alternative Medicine Therapies" at The First International Congress on Alternative and Complementary Medicine in Arlington, Va.

#### **Comments from the mainstream**

Not all alternative practitioners are physicians. And although there are no statistics yet, most physicians in Indiana do not provide alternative therapies and would describe themselves as being in the "mainstream" of medicine today. Here are the comments of three "mainstream" Indiana physicians on the topic of alternative medicine.

#### **Walter J. Daly, M.D., Indianapolis**

"If there are satisfactorily controlled clinical trials, alternative therapies should no longer be alternative. They ought to be incorporated into mainline medicine," says Walter J. Daly, M.D., dean of the Indiana University School of Medicine and director of the IU Medical Center.

Dr. Daly emphasizes that the process whereby new therapies are incorporated and other therapies are discarded is ongoing and evolutionary, one that yields new cancer therapies and new antibiotics. As an example of discarded therapies, he cited bloodletting, which was discredited by clinical trials in France in the late 1700s. But not before Benjamin Rush, physician and signatory of the Declaration of Independence, was awarded the sum of \$5,000 in a defamation of character suit when someone suggested that his practice of aggressive bloodletting was not helpful.

The history of medicine also demonstrates that some unhappy, dissatisfied, panicky and disappointed people benefit, at least psychologically, if they are promised relief. One of Dr. Daly's concerns with alternative therapies, even when mainstream therapies have failed, is that some patients may feel better and

believe they are cured while the disease process continues.

"My point is that it is difficult to know where the truth lies in the absence of controlled clinical studies," says Dr. Daly. He does not have a position on the clinical studies of alternative therapies proposed by Indiana Institute for Complementary Medicine but cautions that "one would have to weigh very carefully the benefits and risks to determine the appropriateness of using patients for that purpose."

While he does not think that it is the business of the medical school to play a part in clinical studies of alternative therapies, he did not close the door completely on that possibility. "We do a lot of clinical trials. It's a very expensive process, labor-intensive, requires lots of time. It's probably the most difficult form of research there is," says Dr. Daly. "I think we would want to know specifically what is being evaluated and what the alternatives are. For so many things, there is a perfectly acceptable form of treatment. You don't want to abandon that to try something different."

#### **John Haste, M.D., Argos**

"He had Parkinson's disease and after a couple of years of being treated with acupuncture and massage therapy, he came in to see me," recalls John Haste, M.D., about one of his patients. "I started him on anti-Parkinson's medications, and the man is significantly improved now. Had he come to me two years earlier, maybe he would have functioned better during those two years of life."

Dr. Haste, a past president of the Indiana Academy of Family Physicians, practices in Argos, a

small town in north central Indiana. In the area, there are several chiropractors, a massage therapist and an acupuncturist. Dr. Haste says these practitioners have taught people better exercise and nutritional habits, but he can't think of any instances where he's seen alternative practitioners get at the root of a medical problem and fix it.

Then again, he says, to give them the benefit of the doubt, he probably sees only their failures. "I don't want to say that I'm so closed-minded that I can't see other people succeeding in certain niches where allopathic medicine can't."

He did, however, relate some cautionary experiences with alternative practitioners. "I've had people come in here that have quit taking their insulin because their chiropractor said if you take enough of these herbs and spices and I manipulate your back every week, you'll no longer need your insulin. And I've had episodes where they've taken all the medicines away from patients that had heart disease because now that they're having chiropractic manipulation, that has *cured* their heart disease. Well, that's crazy."

Dr. Haste's main concern with alternative practitioners is that they may inadvertently delay the diagnosis and treatment of a medical problem. "Several people with arthritis, back ache and pains in their joints have gone to the acupuncturist and they tell me they do feel better. But oftentimes it's not arthritis that makes bones hurt, but some malady that needs more intervention than an acupuncturist could give," he says.

### **Gregory P. Gramelspacher, M.D., Indianapolis**

"As someone trained in traditional medical practice, I'm skeptical of many of the alternative medicine practices," admits Gregory P. Gramelspacher, M.D. "But at the same time, I think there has to be something to it or people wouldn't flock to them."

Dr. Gramelspacher is associate professor of medicine in the division of general internal medicine at the IU School of Medicine and faculty associate with the Poynter Center for the Study of Ethics and American Institutions.

Dr. Gramelspacher concedes that, for many Americans, mainstream medicine may not have all the answers. He speculates that those who use alternative medicine may be dissatisfied with high-tech allopathic medicine and are looking for a more holistic approach that includes things that they aren't getting from their traditional medical practitioners, such as touching or careful listening.

What if his wife were terminally ill with lymphoma, however, and conventional therapy had been unsuccessful, and a colleague gave him the name of an alternative practitioner with some success in treating lymphoma?

"I would thank him for his suggestion and his advice," says Dr. Gramelspacher, "and I would try to come to terms as best I could with the fact that my wife's dying."

Why?

"My knowledge of this particular disease process."

You would not embrace an alternative therapy that may hold out some hope?

"When faced with such a

tragedy, I wouldn't know what to embrace. I support the need to do research in alternative medicine practices, and despite being a mainstream practitioner, I try to incorporate a holistic approach to the practice of medicine."

### **Some common ground**

While some alternative practitioners and mainstream physicians have little to say to each other, others on both sides do share some of the same opinions.

For one thing, none of the alternative practitioners interviewed for this story advocate getting rid of allopathic, high-tech, Western-style medicine. On the contrary, it is their first line of defense against disease and their unanimous choice for acute care situations. Both alternative and mainstream practitioners agree on the need for controlled clinical studies to determine the efficacy of alternative therapies. Most seem to agree that once an alternative therapy is shown to be effective in human clinical trials, it could be incorporated into mainstream medicine. □

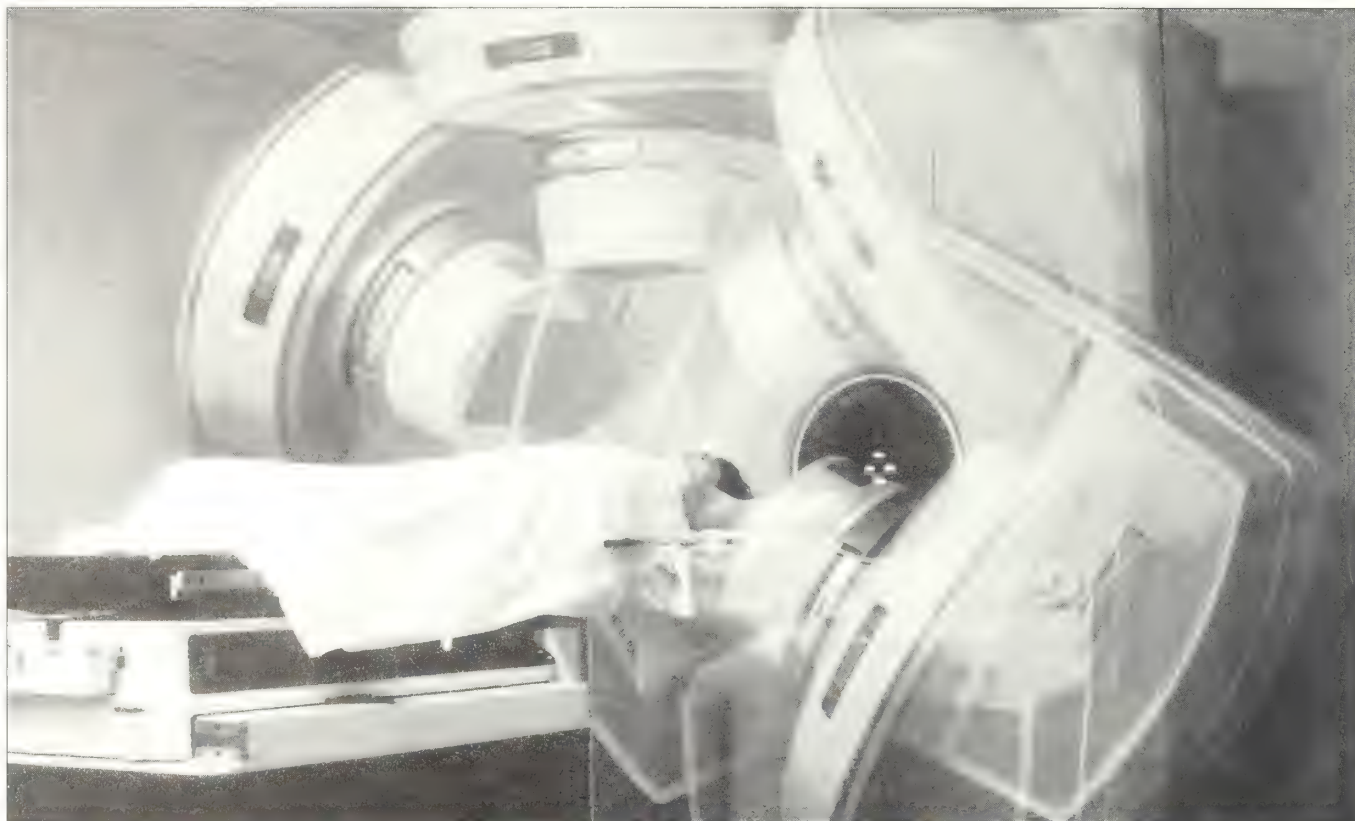
*The author is a health care writer in Indianapolis.*

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# Breast-Conservation Treatment



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# The public needs protection from so-called 'alternatives'

Stephen Barrett, M.D.

In the past two years, there has been a lot of media hype about so-called "alternative medicine." We have been hearing that one out of three Americans uses alternative health care services and that Americans make more visits to alternative providers than to primary care practitioners. We've also been hearing that the establishment of the Office of Alternative Medicine (OAM) within the National Institutes of Health (NIH) indicates that alternatives are moving toward the scientific mainstream.

## Public misconceptions

These statements are misleading. The first two were generated by an article published in *The New England Journal of Medicine* by David Eisenberg, M.D., and his colleagues, who interviewed 1,500 adults about their use of "unconventional" therapies.

Dr. Eisenberg and company defined unconventional therapies as treatments neither widely taught in medical schools nor generally available in U.S. hospitals. Then they selected 16 treatment categories, some of which did not fit their own definition and would be considered conventional by many mainstream physicians. Relaxation techniques, for example, when properly used, may be a useful adjunct to psychotherapy. Other nebulous categories included commercial weight loss clinics, massage, hypnosis, bio-feedback and self-help groups, which, depending on how they are conducted, may or may not be

science-based. About 40% of the visits reported by participants in the survey fell into these six categories.<sup>1</sup> Armed with the Eisenberg paper, the media translated "unconventional" into "alternative" and began issuing one misleading report after another. I believe that this publicity will induce millions of Americans to become victims of quackery.

Until recently, the medical literature has referred to alternatives as methods that have equal value for a particular purpose. (An example would be radiation versus surgery for certain cancers.) Today, however, the term is loosely applied to methods that are generally not accepted by the scientific community. I define alternatives as methods generally not accepted by the scientific community and lacking a plausible rationale. In other words, they are not *genuine* alternatives to effective treatment.

Actually, these methods vary so much that it is better to discuss them individually rather than as a group. It is also important to realize that some so-called alternatives encompass not one but many approaches. Some chiropractors, for example, know their limitations and provide appropriate care for musculoskeletal ailments, whereas others think that manipulating the spine throughout life on a weekly or monthly basis stimulates the body's "life energy" and therefore is the key to good health. Moreover, a method can be rational in one context and irrational in another. A massage given to soothe an aching part of the body is not an unconventional practice.

A massage given to "rid the body of toxins" is another matter.

## Unsubstantiated claims

In 1991, the U.S. Congress ordered the NIH to set up an office to investigate unconventional methods of treatment. Both the NIH office and the Eisenberg article became magnets for press coverage. The typical media report, however, treated them as straight news events without considering what unconventional methods involve. Most reports have contained interviews with practitioners or laundry lists of their practices, using different definitions supplied by proponents. Few reporters have tried to examine what these practitioners actually do.

One problem is that many "alternative" practitioners misrepresent what they do. The simplest illustration is the claim by chiropractors, naturopaths and homeopaths that they place more emphasis than the medical profession does on preventive care. Look closely, however, and you will find that many of them do not support water fluoridation and are either opposed to, or lukewarm toward, immunization.

Thanks to the publicity bandwagon, so-called alternative methods could be used more frequently now than they were a few years ago. However, frequency-of-use data have not been published for most of them. Regardless of the popularity of these methods, I know of no research to substantiate the claim that people turn to alternatives because they are dissatisfied with their medical care. A study in New



Zealand of 148 cancer patients using alternative approaches found that most were satisfied with conventional medicine and accepted alternative therapy only as a supplement.<sup>2</sup> Blaming medicine for quackery's persistence is like blaming astronomers for the popularity of astrology. Some people's needs exceed what ethical, scientific health care can provide. The main reason for quackery's success is its ability to seduce unsuspecting people. Much of its popularity stems from claiming credit for recovery from self-limiting ailments.

#### Regulatory stew

American consumers have far less protection than they realize. Practitioners are under the jurisdiction of state licensing boards. Products are regulated by federal and state agencies. The U.S. Food and Drug Administration has jurisdiction over labeling. The Federal Trade Commission oversees advertising of nonprescription products, and the U.S. Postal Service covers items sold through the mail. In theory, if you can't prove something, you shouldn't be able to market it to the general public. But none of these agencies has the resources to handle most of the violations they encounter. In addition, they are often thwarted by the complexity, inefficiency and overcrowding of our court system.

Unquestionably, we need more regulation. The most practical approach might be to convene a task force of regulators and other interested parties to determine the most efficient way to use existing resources and the extent to which additional resources are needed. Meanwhile, it would help if regulatory agencies revealed the

number of illegal activities they encounter and what percentage of them they can stop.

#### What are we paying for?

Without state mandates, traditional insurance companies and managed care plans are generally unwilling to pay for unproved treatments. Some insurance policies cover the office-visit portion of a so-called alternative treatment by physicians but not the treatment itself. In most states, laws have been passed to force coverage of chiropractic treatment, but the extent of this coverage can vary from state to state and plan to plan.

Mutual of Omaha is testing whether participation in the program of cardiologist Dean Ornish, M.D., is cost-effective against coronary artery disease. The program includes a 10% fat diet plus regular exercise, smoking cessation, weight control, stress-reduction techniques and group counseling. Dr. Ornish has some far-out ideas, but he has documented positive preliminary findings with before and after angiograms. In other words, he has acted like a scientist, not a quack. Many mainstream physicians don't consider what Dr. Ornish is doing to be "alternative" and neither do the officials at Mutual of Omaha who made the decision to experiment with insurance coverage.

If NIH studies substantiate some of the claims made for alternative methods, it is possible that some insurance carriers will reconsider their views. However, I doubt that any of the so-called alternative methods will prove useful. Furthermore, it is not clear how much investigating the NIH's

OAM will actually do. The limited amount of money available for research grants is unlikely to produce much more than preliminary data.

For now, no one knows what type of alternative techniques could be included in a national benefits package – assuming that Congress succeeds in passing health system reform. Chiropractors are lobbying aggressively to be included as primary care providers. The data on chiropractic are conflicting. As far as I know, no valid data have been published for other unconventional practices. It would be a terrible mistake for the federal government to force insurance companies or managed care plans to pay for unproved methods. What we need is greater public protection, not expanded access to methods that are not helpful. □

*The author, a retired psychiatrist, is a board member of the National Council Against Health Fraud. His 36 books include the American Medical Association's Reader's Guide to "Alternative" Health Methods and The Health Robbers: A Close Look at Quackery in America.*

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# State health reform bill pleases physicians

**Mike Abrams**  
ISMA Director of  
Government Relations

Is there nothing beyond the reach of legislation? In 1897, a bill was introduced in the Indiana General Assembly by Rep. Taylor Record from New Harmony to change the value of *pi* from 3.1415926535 to 3.2. The bill passed the House unanimously but died in the Senate.

Although nothing quite that unusual was considered during the 1995 session, Indiana legislators wrestled with a large number of issues in which medicine held a stake.

For the past several years, the legislative success of the Indiana State Medical Association (ISMA) has been measured not in terms of what we helped get enacted but in what we stopped from being enacted. If Indiana legislators did not pass anything that the ISMA opposed, the session was considered a booming success.

While nothing passed the 1995 legislative session to which physicians expressed strong opposition, the session can be discussed in terms of what passed that Indiana physicians support.

Twelve months ago, the words "health system reform" were words that invoked fear in the hearts of many physicians. People spoke in terms of government takeovers, comprehensive overhauls of the nation's medical education system and severe restrictions on professional fees charged by physicians. During the recently adjourned Indiana legislative session, health reform

legislation took a form that received enthusiastic support from the physician community. Introduced in the

Senate by Sen. Patricia Miller (R-Indianapolis) and in the House of Representatives by Rep. Vaneta Becker (R-Evansville), health reform legislation could be more accurately described as health insurance reform legislation. Legislators realized that, while there are problems with the current



**Sen. Miller**



**Rep. Becker**

system, much of the problem rests not with how health care is delivered but with how health care is financed. With that philosophy in mind, Senate Bill 576 was born.

At no time during the legislative process did SB 576 contain language to which physicians were opposed. Most of the components of the bill received the support of physicians, hospitals and even insurance companies during the entire process. But while there was wide consensus on many components, stakeholders in the debate also disagreed on several issues.

## **Health reform debate**

Virtually all parties involved with the health system reform debate agreed on six policy areas:

a) Health care savings ac-

counts: SB 576 includes language that allows a state tax deduction for money that employers set aside for employees' health expenses and sets up the requirements for health care savings accounts.

b) Increase applicability of small group health reforms: Current federal law prohibits state legislatures from applying state law to self-insured plans (Employee Retirement Income Security Act). Therefore, most of SB 576 affects only small group health insurance plans. Before the enactment of SB 576, a small group was defined as a group having between three and 25 employees. SB 576 expands the definition of small group to mean any group with between three and 50 employees. This will allow the insurance underwriting protections embodied in SB 576 to apply to more people.

c) Portability: No stakeholder opposed language to provide insurance portability, which is the concept of allowing a pre-existing condition period, once served, to be carried over to future employers. Under this provision, once an employee serves a pre-existing condition period, if that employee leaves the job and goes to a new employer, the new employer insurer cannot require the employee to go through another pre-existing condition period.

d) Guaranteed renewability: There was consensus that insurers should not be allowed to cancel an insurance policy just because one of the insureds got sick. SB 576 clearly outlines those reasons for which an insurer can refuse to renew a policy, including failure to pay premiums and fraud.

e) Industry blacklisting: SB 576 prohibits insurers from identifying industries that they will refuse to insure.

f) Whole group underwriting: Language that prohibits insurers from "cherry picking," or insuring only the healthy members of the small group, was included in the final version of SB 576.

Even though there were areas of agreement in the legislation, some elements of the legislation were debated for most of the session before agreements were reached.

#### **Pre-existing conditions**

The issue of pre-existing condition restrictions presented lawmakers with an important policy dispute to work out. Under current law, there is no limit on the length of time that an insurer may exclude coverage of a pre-existing condition. Even with no statutory restriction, most insurance policies written for small groups limit coverage of pre-existing conditions for twelve months, although some small group policies exclude coverage for longer periods of time.

Lobbyists for the insurance industry, the State Chamber of Commerce and the Indiana Manufacturers Association lobbied strongly to set the pre-existing condition restriction at 12 months. Realizing that setting the statutory restriction at 12 months represented no progress, the ISMA pursued a much more restrictive law, stating that people who pay insurance premiums should not be prohibited from getting claims paid for the very things that they

are likely to need coverage for. The American Diabetic Association and other patient advocacy groups, as well as the Indiana Hospital Association, agreed with the ISMA and lobbied strongly for a restrictive pre-existing coverage statute. The business community claimed that a law much more restrictive than twelve months would make insurance for small businesses much too expensive and, therefore, small businesses would drop insurance coverage for their employees.

In the end, legislators adopted a pre-existing condition restriction of nine months. Under this provision, an insurer cannot exclude

option, if an employee leaves an employer, the employee can continue coverage, remaining a part of the employer's small group, and the employee pays the entire premium associated with the coverage, which is limited to 102% of the original premium. This option, which is modeled after the federal COBRA law (which applies only to employers with 20 or more employees) was vehemently opposed by the Indiana State Chamber of Commerce and the Indiana Manufacturers Association. Both of those groups indicated that continuation policies would cause greater expense to their risk pools and

therefore drive up the costs of those policies for the employers who remain a part of the small group. Legislators presented information

to discount those claims, but the business community made a priority of defeating any legislation that included continuation requirements.

The other option for covering the transiently uninsured is called *conversion*. Under this option, one who leaves an employer may convert coverage from a small group policy to an individual insurance policy, paying premiums directly to the insurance company. While the business community preferred this method of coverage, some key legislators felt that the continuation method would be easier on people and more affordable. Conversion policies are limited to 150% of the premiums, while continuation policies are cheaper at 102% of the premiums.

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### ***In the end, legislators adopted a pre-existing condition restriction of nine months.***

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coverage for any condition that existed within the previous nine months of the policy's effective date for more than nine months after the policy's effective date.

#### **Continuation vs. conversion**

Another area of great disagreement was how to cover employees who leave employers. The state health policy commission's report indicated that 11% of Hoosiers are uninsured, and of that number, 80% are transiently uninsured or uninsured only for a short time. For that reason, the method adopted by the legislature to cover those people who leave employers was one of the most important elements of the debate.

One option for covering people who leave employers is called *continuation*. Under this



In the final hours of the session, legislators agreed to insert language providing for conversion policies through 1998. In 1998, *if the legislature approves a mechanism to offset the additional costs to business*, such as a tax credit, continuation policies would come into effect.

### **Anti-hassle legislation**

Indiana physicians have expressed extreme frustration during the past several months about the state Medicaid program. Claims not paid, radical shifts in reimbursement policy with no advance notice and many other valid complaints have caused the Medicaid program to lose credibility among health care providers and patients. In response to those complaints, the ISMA worked diligently during the 1995 legislative session to enact Medicaid anti-hassle legislation. After months of grassroots work by ISMA members, as well as hard negotiation by several interest groups, House Bill 1758 was enacted to mitigate some of the administrative burden associated with treating Medicaid patients.

When HB 1758 was originally introduced by Rep. Vaneta Becker, it called for the establishment of a 19-member board as the ultimate authority over the Family and Social Services Administration (FSSA). The FSSA oversees not only Medicaid but mental health, aging and rehabilitative services and many other human services programs.

Legislators became keenly aware that problems at FSSA were pervasive when not only every member of the health care community stepped up to support HB 1758, but support also came from the American Association of

Retired Persons, the Mental Health Association, the Human Services Coalition and virtually every other group that interacts with the agency. With such a broad-based show of support, passage looked likely from the beginning.

Rep. Mary Kay Budak (R-LaPorte), chairman of the House Human Affairs Committee, held a hearing on HB 1758, and several groups testified in support of the bill. Representatives from the FSSA testified that establishing a board of citizens made the agency more bureaucratic and would hamper the agency's ability to save money in the programs it administers. Supporters of the bill testified that no accountability is evident in the agency at this time, and a board of citizens would increase public input into the many programs administered by the agency.

After lengthy testimony, the bill passed Rep. Budak's committee with a vote of 9-2. Those voting in favor: Reps. Budak; John Becker (R-Fort Wayne); Barb Engle (D-Decatur); Candy Morris (R-Indianapolis); Bruce Munson (R-Muncie); Greg Porter (D-Indianapolis); Sue Scholer (R-West Lafayette); Vernon Smith (D-Gary); and Phil Warner (R-Goshen). Those voting in opposition: Reps. Dennis Avery (D-Evansville) and Mae Dickinson (D-Indianapolis).

The threat of a gubernatorial veto made negotiation and compromise necessary, and several weeks were spent trying to rewrite the bill so that it would not be vetoed by Gov. Evan Bayh. The final version of the bill contained language establishing a 15-member board that would be required to approve any rules promulgated by FSSA. Although the board would not be the agency's ultimate authority, no rules could be

adopted unless the 15-member board approved them. One of the 15 members of the board has to be a physician.

Anti-hassle language also was introduced in House Bill 1726 by Rep. Phil Warner. The language from his bill was included in HB 1758 and will be welcome relief to Indiana physicians. This language prohibits any Medicaid bulletin from taking effect sooner than 45 days after providers are notified of the change. In addition, the Medicaid program must establish a panel of clinicians to advise the agency of any changes in medical policies that Medicaid considers.

HB 1758 ultimately passed the General Assembly with little opposition. After passing the House committee, it passed the House floor with a 93-5 vote. In the Senate, it gained the unanimous approval of Sen. Miller's health committee and was approved by the full Senate 49-0.

### **Other legislation enacted**

Several other pieces of legislation of importance to Indiana physicians were enacted this session. Among them:

- Senate Bill 90 (authored by Sen. Patricia Miller): Expands the Good Samaritan Act to include emergencies as well as accidents. Excludes emergency care delivered to patients in hospitals.

- House Bill 1623 (authored by Rep. Dave Frizzell): Requires the attorney general to notify a physician before the medical licensing board can consider issuing a summary suspension of a physician's license.

- Senate Bill 76 (authored by Sen. Marvin Riegsecker): Establishes a system whereby local units of government may indemnify care rendered in charity clinics. If a



local unit of government insures the clinic, care providers may not be held liable for care rendered in the clinic.

- Senate Bill 658 (authored by Sen. Potch Wheeler): Gives physicians and other health care providers due process rights if they are

discharged from HMO panels for quality of care issues.

Legislators worked up until the last possible moment before adjourning Saturday, April 29, at midnight. After considering 1,514 bills and passing 361 of them, *pi* is still 3.14. □

*The Digest of Health and Medical Laws, which summarizes all health care legislation enacted in 1995, will be published in the September/October issue of Indiana Medicine.*

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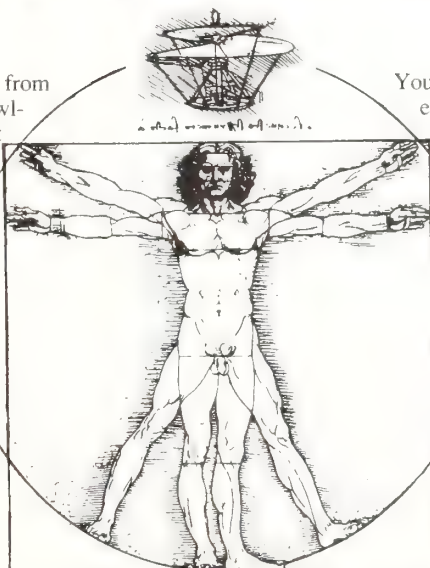
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# AMA looks at ways to reform Medicare

**Mike Abrams**  
ISMA Director of  
Government Relations

Lobbying against severe Medicare cuts has been an annual exercise for physicians across America for many years. The president and Congress propose cuts, physicians and other providers oppose them, and cuts are implemented, usually at a level less than what was originally proposed.

According to AMA figures, provider payments from Medicare between 1981 and 1993 have been reduced by \$98 billion. Although physicians account for only 23% of the Medicare outlays, they have absorbed 32% of provider cuts over the last decade.

The elections of 1994 emboldened those legislators who work feverishly to balance the federal budget. Voters sent a message, they say, to scale back the size and shape of government.

Perhaps more than any other year, Medicare cuts seem to be inevitable. The question is no longer whether the Medicare budget will be cut but how much it will be cut.

One strategy that could be adopted by Medicare stakeholders is to simply oppose the cuts. This

is the strategy that has been adopted by the American Hospital Association and other providers who would be hurt by massive cuts. Adoption of this strategy, however, threatens to alienate legislators who are not entertaining the notion of balancing the budget without cutting Medicare.

The strategy adopted by the American Medical Association recognizes the inevitability of some level of Medicare cut and then works to fundamentally change the way Medicare is implemented in order to affect savings within the Medicare budget.

The AMA has suggested that Medicare reform be based on four principles:

1. Cost-consciousness on the part of beneficiaries: The Medicare Part B premium was originally set to cover 50% of program costs, but if current trends continue, it will cover only 25% of costs. Premiums should reflect the income of the beneficiary. Also, tax law changes to create incentives to encourage investments in medical savings accounts are necessary.

2. Expand insurance options for beneficiaries: Private insurance options should be available to Medicare beneficiaries, with the current Medicare benefit package retained as an option. Patients

should continue to be free to choose their own physicians.

3. Reduce intergenerational inequity in financing: Absent a significant change in the financing of Medicare, workers will continue to experience a significantly higher tax burden to fund the existing program.

4. Anti-hassle: Time and other scarce resources that could and should be devoted to patient care are instead directed toward keeping up with a continuing stream of regulations and paperwork associated with CLIA, medical utilization review and claims processing requirements.

Cutting Medicare without addressing some of the underlying reasons as to why Medicare is expensive is short-sighted and should be avoided.

The House budget calls for \$283 billion in Medicare cuts, and the Senate budget calls for \$256 billion in cuts.

The debate on this critical issue is just beginning, and the budget will go through many changes before it is finally adopted. Nonetheless, the campaign to implement responsible administration of the Medicare program will consume a great deal of time on the part of organized medicine and other groups with interest in this program. □

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# AMA's study of Federation looks at future needs, concerns

**T**he Study of the Federation is an effort by organized medicine to meet the future needs and concerns of physicians. It is designed to develop recommendations to organized medicine on what it has to do to succeed in the future.

The changing health care environment will create new needs, issues and concerns for physicians. Responding to the new environment will require changes in medical associations and changes in the relationships among medical associations.

The project will produce recommendations that redefine relationships in organized medicine in order to:

- enable the medical profession to speak with one voice on critical issues;
- create more effective ways to accomplish work on behalf of the medical profession;
- eliminate or minimize duplication of services between medical societies; and
- focus each element of organized medicine on what it does best.

Participants in the study include physicians and medical society staff from the AMA; state, county and specialty medical societies; and ethnic organizations. The study is being conducted by a consortium of more than 200 members and a 28-member project team.

Indiana physicians participating in the study are William Beeson, M.D., Indianapolis; Shirley Khalouf, M.D., Marion; Michael Mellinger, M.D., LaGrange; and Marvin Priddy, M.D., Fort Wayne.

Three types of research are being done: focus groups with member and non-member grassroots physicians, telephone interviews with leaders of organizations that have a relationship with organized medicine and site visits with physician and staff leadership of five state societies, four county societies and four specialty societies.

Four major areas of consensus have emerged from the research regarding the wants and needs of physicians in the year 2000:

- Physicians will need greater public trust and credibility and an improved image as patient advocates.
- Physicians must be involved in defining quality care, practice parameters and standards of care.
- Physicians will need effective representation that is focused on the future, not protecting the past.
- Physicians need better preparation for the changing practice environment.

## Research on roles

Research indicates that each element of organized medicine has an important role to play in meeting the future needs of physicians. Here are highlights from discussions on what the roles of the various medical groups should be:

- The AMA should focus on:
  - Practice standards and outcomes
  - Coordination of specialty efforts
  - Enhancements of physician image
  - Ethics

- Acting as voice of physicians
- Public policy
- Asking physicians what they want
- Information

The AMA should reduce focus on:

- Ancillary businesses
- Internal politics
- Leader-driven ivory tower thinking
- Efforts to maintain the status quo

State medical societies should focus on:

- Political influence on the state level
- Maintaining standards and quality
- Communication links
- Networks of physicians to solve common problems.
- Forums for discussion among specialties
- Public health issues in the state

State medical societies should reduce focus on:

- Peer review
- High membership fees
- State journal
- Club atmosphere
- Scientific and clinical education
- Internal politics

Local medical societies should focus on:

- Public education and advocacy
  - Peer review
  - Information exchange
  - Community action

Local medical societies should reduce focus on:

- Club atmosphere
- High membership fees

Specialty medical societies should focus on:

- CME
- Practice parameters/guidelines, quality outcomes and related research
- Communication with AMA, state and other specialties
- National training standards
- Inter-specialty cooperation

Specialty medical societies should reduce focus on:

- Self-interest activities
- Income protection for subspecialties

#### **Strategy outlined**

Research findings support the

following five elements of a strategy to reinvent the Federation:

- Major changes in medical associations, even to the point of substantial redefinition of purpose and roles, will be needed in order to respond to the changing needs of physicians.
- To be more responsive to the changing needs of physicians, medical associations must establish a new federation of medicine that is more cooperative, integrated and efficient.
- The existing categories of medical associations provide the basic elements needed to design a new federation of medicine.
- The components of the new federation of medicine should

continue to be physician-oriented associations, and the members of medical associations should continue to be individual physicians.

- The representational mechanisms used by medical associations need to be revamped to more accurately reflect critical characteristics of the physician population, including geographic location, specialty, practice arrangement, career stage and demographic groupings. □

# PICI affiliates with Mutual Assurance, Inc.

The Indiana State Medical Association has announced that Physicians Insurance Company of Indiana has completed a business combination with Mutual Assurance Inc. (MAIC), one of the strongest and most successful medical professional liability insurers in the nation.

MAIC, formed in 1976, has consolidated total assets of more than \$500 million and shareholders' equity exceeds \$150 million. The company, headquartered in Birmingham, Ala., is licensed in 15 states and is a

major insurer of physicians, hospitals and managed care organizations. M. David Duncan, president and CEO of PICI, said,

"PICI and MAIC have very similar founding and operating objectives, and both companies have close relationships with sponsoring state medical associations. Most importantly, for Indiana physicians, Mutual Assurance has maintained an A+ (superior) rating from A.M. Best since 1984." Duncan said he expects PICI to also receive the A+ rating as a result of this affiliation.

PICI's affiliation with MAIC

was accomplished through MAIC's purchase of PICI stock from the ISMA, the company's majority shareholder, and PICOM Insurance Company, the company's largest minority shareholder. The ISMA's direct and guiding involvement with PICI continues through a long-term endorsement agreement. Indiana physicians will continue to constitute a majority on the company's board of directors and serve a vital leadership role on the company's claims and underwriting committees. There are no

Today changes in the health care delivery system are creating professional liability challenges that will best be met by insuring entities with large financial resources who are prepared for the marketplace of the future. PICI, with nearly 3,500 policyholders and total assets of over \$40 million, has exceeded our expectations in bringing innovative coverages, risk management and a commitment to serve Indiana physicians. Now, as the Midwestern hub of the MAIC organization, PICI's future is secure. We are part of a regional

insuring organization fully prepared to meet the present and future challenges of insuring physicians, dentists, hospitals and health care facilities, managed care

plans and other emerging health care entities."

The ISMA and PICI will continue working together, with the full support of MAIC, to make a difference in professional liability protection. The ISMA's dedication to a stable professional liability environment in Indiana remains firm and is only strengthened by PICI's alliance with Mutual Assurance. □

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***'There are no changes in the terms and conditions of PICI's insurance contracts, and service commitments to policyholders ...'***

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changes in the terms and conditions of PICI's insurance contracts, and service commitments to policyholders, and PICI will continue to operate under the direction of its current management and staff.

John MacDougall, M.D., chairman of the board of PICI, said, "PICI has entered an exciting new era, one that will offer substantially broadened horizons.



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# Physicians serve as mentors to Girl Scouts

Indiana physicians are introducing Girl Scouts to the exciting possibilities of careers in medicine through the Physicians of Tomorrow Mentoring Program. Through the joint efforts of the Indiana State Medical Association and Girl Scout councils around the state, scouts are paired with a physician for a firsthand look at medicine.

The Hoosier Capital Girl Scout Council, consisting of Indianapolis and surrounding counties, was the first council in the state to participate in the program. Other councils that will participate are Drifting Dunes, Singing Sands, Indiana Lakeland, Limberlost, Tribal Trails, Wapehani, Covered Bridge, Tulip Trace, Treaty Line and Raintree.

Forty physicians are enrolled as mentors so far, but more are needed. To register as a mentor, call Tim Brent at the ISMA, (317) 261-2060 or 1-800-257-4762, before Aug. 1.

Indianapolis area physicians and scouts from the Hoosier Capital Girl Scout Council are pictured here. An awards ceremony for the scouts was held in May at the Indiana Medical History Museum. □



Betty Lou Walsman, M.D., a neonatal-perinatal medicine specialist at Women's Hospital of Indianapolis, shows Sarah Beth Sutor around the nursery.



Debbie Hulbert, M.D., an Indianapolis pediatrician, with Amber Worman.





Brenda Gierhart, M.D., an Indianapolis obstetrician/gynecologist, with Shandias Smith.



Gwendolyn Niebler, M.D., an Indianapolis neurologist, with Nicole Flint.



Sheila Gamache, M.D., an Indianapolis cardiologist, with Brooke Costides.



Maria Fletcher, M.D., a family practice physician in Brownsburg, with Julia Ann Hunt.



# Should you form a family partnership?

Joel M. Blau, CFP  
AMA Investment Advisers, L.P.

Starting a gifting program to your children can be an effective way to reduce your overall future estate tax liability. Estate taxes can be eliminated or minimized by taking advantage of the \$10,000 per donee, per year annual exclusion. Married donors can give a total of \$20,000 per donee annually.

Many physicians may be reluctant to transfer significant amounts to children who may lack adequate financial management skills. For this situation, the formation of a family limited partnership may be useful. This strategy, which is legal in most states, allows you to give away your wealth without giving up control.

You transfer property such as your medical office building or other investment real estate or securities to a newly formed limited partnership, tax-free, in exchange for both general and

limited partnership interests. As the general partner, you continue to have authority to manage all partnership assets. You could then gift limited partnership interests each year to your children or other family members. As limited partners, they would be termed "passive" investors who have no direct say in the operation of the partnership while you are alive. At your death, the partnership can be dissolved, and each limited partner would then receive a proportionate share of all existing partnership assets.

There are drawbacks to forming and operating a family partnership. Substantial legal fees may be charged to draft the actual partnership agreement. Establishing sustainable gift tax discounts can be difficult and may require a costly professional appraisal, especially when real estate is involved. Also, you will need to make cash distributions to the limited partners while you are alive. This is important because the limited partners may be taxed on their share of partnership earnings

without having the necessary funds to pay their income tax obligation.

Much has been written about the advantages of family limited partnerships. Attorneys around the country are presenting seminars on family limited partnerships as a relatively new, sophisticated strategy to minimize your future estate tax liability. Unfortunately, this technique does not work in all situations. The benefits of family partnerships, like many other tax savings strategies, will vary based on your specific circumstances. The key is to structure an efficient estate plan that is optimal for your own family and financial situation. It is important to consult with your accountant as well as your attorney to determine the feasibility of a family partnership as part of your overall estate plan. □

*The author welcomes readers' questions. He can be reached at 1-800-262-3863.*

# 1994 Indiana State Medical Association membership report

	Active	Resident	Inactive	Total
Adams .....	10	0	6	16
Bartholomew/Brown .....	101	0	17	118
Benton .....	1	0	1	2
Boone .....	15	1	11	27
Carroll .....	7	0	1	8
Cass .....	33	1	10	44
Clark .....	95	1	12	108
Clay .....	9	0	4	13
Clinton .....	15	0	3	18
Daviess/Martin .....	12	1	9	22
Dearborn/Ohio .....	34	0	3	37
Decatur .....	10	0	3	13
DeKalb .....	13	0	4	17
Delaware/Blackford .....	167	3	34	204
Dubois .....	41	2	4	47
Elkhart .....	131	0	40	171
Fayette/Franklin .....	20	0	5	25
Floyd .....	79	1	19	99
Fort Wayne (Allen) .....	474	41	106	621
Fountain/Warren .....	7	0	4	11
Fulton .....	7	0	1	8
Gibson .....	10	0	3	13
Grant .....	67	2	24	93
Greene .....	11	0	7	18
Hamilton .....	67	2	6	75
Hancock .....	33	0	10	43
Harrison/Crawford .....	13	0	1	14
Hendricks .....	59	0	6	65
Henry .....	22	1	11	34
Howard .....	96	0	28	124
Huntington .....	16	0	6	22
Indpls. (Marion) .....	1,619	35	331	1,985
Jackson .....	21	0	6	27
Jennings .....	3	0	1	4
Jasper/Newton .....	11	0	4	15
Jay .....	13	0	5	18
Jefferson/Switzerland .....	32	0	9	41
Johnson .....	55	0	8	63
Knox .....	53	0	15	68
Kosciusko .....	29	0	4	33
LaGrange .....	11	0	4	15
Lake .....	608	1	123	732

	Active	Resident	Inactive	Total
LaPorte .....	110	0	28	138
Lawrence .....	39	0	9	48
Madison .....	131	1	41	173
Marshall .....	14	0	6	20
Miami .....	14	0	3	17
Monroe/Owen .....	178	2	24	204
Montgomery .....	31	0	10	41
Morgan .....	25	0	4	29
Noble .....	13	0	2	15
Orange .....	5	0	2	7
Perry .....	5	0	1	6
Pike .....	1	0	0	1
Porter .....	117	2	18	137
Posey .....	2	0	1	3
Pulaski .....	6	0	1	7
Putnam .....	10	0	7	17
Randolph .....	8	0	4	12
Ripley .....	12	0	0	12
Rush .....	10	0	1	11
St. Joseph .....	285	6	93	384
Scott .....	7	0	1	8
Shelby .....	16	0	5	21
Spencer .....	1	0	0	1
Starke .....	7	0	3	10
Steuben .....	10	0	5	15
Sullivan .....	3	0	5	8
Tippecanoe .....	195	1	49	245
Tipton .....	6	0	2	8
Vanderburgh .....	378	0	87	465
Vigo/Parke/Vermillion .....	132	0	35	167
Wabash .....	24	0	8	32
Warrick .....	17	0	0	17
Washington .....	7	1	2	10
Wayne/Union .....	82	0	30	112
Wells .....	38	0	18	56
White .....	4	0	4	8
Whitley .....	6	0	5	11
RMS .....	0	69	0	69
1994 totals .....	6,079	174	1,423	7,676
1993 totals .....	6,048	171	1,351	7,570

\* Totals as of Dec. 31, 1994.

## Membership information

	Active members	Chg from prior yr. active members:	Chg from prior yr. dues exempt mbrs:	Total:
1994 .....	6,253	+34	1,423 (+72)	7,676
1993 .....	6,219	+ 101	1,351 (+60)	7,570
1992 .....	6,118	+ 103	1,291 (+68)	7,409
1991 .....	6,015	- 72	1,223 (+106)	7,238
1990 .....	6,087	+ 68	1,117 (+29)	7,204

# Hodgkin's lymphoma presenting in two siblings with atypical pseudocholinesterase

Christopher Wolfla, M.D.  
Lewis Jacobson, M.D.  
Indianapolis

**H**odgkin's lymphoma is a malignant tumor of lymphoid origin characterized histologically by the presence of neoplastic giant cells, called Reed-Sternberg cells, admixed with a variable inflammatory component. Clinically, it is characterized by contiguous lymphatic spread and the absence of a leukemic component.<sup>1</sup> It is a rare neoplasm, comprising only 0.7% of all new cancer cases by recent estimates. Approximately 7,400 new cases were observed in 1989.<sup>2</sup> The mixed-cellularity variety makes up 20% to 40% of all cases of Hodgkin's lymphoma.<sup>1</sup> Despite intense research, it is unknown whether genetic or environmental factors are more important in the etiology of this malignancy.

A more commonly occurring condition is that of atypical pseudocholinesterase. Prolonged neuromuscular blockade after succinylcholine administration is usually associated with atypical pseudocholinesterases. The genetics of atypical pseudocholinesterase are classic Mendelian in that two alleles exist, each one inherited from a parent. Atypical pseudocholinesterases are classified by alterations in their enzymatic activity when exposed to

## Abstract

A 21-year-old white man was admitted with a diagnosis of mixed cellularity Hodgkin's lymphoma for staging laparotomy. His family history was positive for a brother who had both Hodgkin's lymphoma and atypical pseudocholinesterase. Serum pseudocholinesterase activity, dibucaine number and fluoride number were obtained, revealing markedly decreased pseudocholinesterase activity and dibucaine number, with an only slightly decreased fluoride number, consistent with homozygous type E<sub>1</sub>A atypical pseudocholinesterase. After induction of anesthesia using vecuronium, a staging laparotomy was performed without complication. Through a discussion of what is known of the genetics of Hodgkin's disease and atypical pseudocholinesterase, we conclude that the association between the two conditions is very rare but more likely due to chance than to genetic linkage.

dibucaine and fluoride. The dibucaine detected variants are the most important clinically since the heterozygous atypical variant occurs in about one in 480 individuals and the homozygous variant occurs in about one in 3,200.

In this article we describe a patient with Hodgkin's disease and atypical pseudocholinesterase whose brother had the same conditions. Consideration is then given to the idea that Hodgkin's disease and atypical pseudocholinesterase are genetically linked.

## Case report

A 21-year-old man was admitted to the hospital with a diagnosis of Hodgkin's lymphoma. The patient first noticed the onset of weakness,

fatigue, headache and decreased appetite four months before admission. A diagnosis of sinus infection was made, and the patient was treated with oral antibiotics. The patient's symptoms did not improve, and he developed bilateral supraclavicular lymphadenopathy. A left supraclavicular lymph node biopsy was performed at a naval hospital in another state two months before admission. This revealed Hodgkin's lymphoma of the mixed cellularity type. A staging workup, consisting of computerized axial tomography of the chest, abdomen and pelvis, bone marrow biopsy and lymphangiogram was initiated, which revealed no evidence of metastatic spread. Physicians



determined that the patient would require a staging laparotomy and referred him to an Indianapolis hospital. At the time of admission, the patient had no complaints and reported no fevers, chills or night sweats.

The patient's past medical history was remarkable only for a cleft palate, which was repaired at two years of age. There were no reported problems with anesthesia. The supraclavicular lymph node biopsy described above was performed under local anesthesia. On admission, he was taking no medications, had no allergies and did not use tobacco, alcohol or recreational drugs.

The patient's family history was significant for a brother, age 23, who also had Hodgkin's lymphoma. This was discovered at age 22, was of the nodular sclerosing type and was stage IIIA at diagnosis. Interestingly, this brother manifested delayed recovery (approximately 180 minutes) from neuromuscular blockade used during induction of general anesthesia for a lymph node biopsy. The diagnosis of atypical pseudocholinesterase was made. The patient has another brother who underwent surgery as an infant for pyloric stenosis, reportedly without difficulty.

The patient's physical examination was remarkable only for bilateral supraclavicular lymphadenopathy and a well-healed left supraclavicular incision. Routine laboratory studies, including serum electrolytes, glucose, urea nitrogen, creatinine, bilirubin, calcium and phosphorus, were within normal limits, as were a complete blood count, prothrombin time, partial thromboplastin time and platelet count.

Because of the patient's family

Table			
Laboratory values of index patient			
Laboratory value*	Normal <sup>+</sup>	2/4/92	2/5/92
Pseudocholinesterase activity (IU/ml) .....	17-19 .....	2.8 .....	1.9 .....
Dibucaine number .....	81-87 .....	15 .....	27 .....
Fluoride number .....	44-54 .....	39 .....	45 .....

\* All tests performed at Indiana University Hospitals in Indianapolis.  
<sup>+</sup> Normal values as defined by Department of Pathology, Indiana University Hospitals.

history of atypical pseudocholinesterase, a laboratory workup was initiated (Table). This revealed a marked decrease in the plasma pseudocholinesterase activity and dibucaine number, with a slightly decreased to low-normal fluoride number. The results were consistent with homozygous type E<sub>1</sub><sup>a</sup> atypical pseudocholinesterase. A peripheral blood karyotype was performed after the initiation of chemotherapy. This was interpreted as normal male, with a subpopulation of cells exhibiting various abnormalities, probably the result of the patient's chemotherapy treatment. There were no consistent abnormalities.

Questioning of the patient's family revealed that at least two other members had tested positive for atypical pseudocholinesterase, although specific laboratory data are not available (Figure). Neither of the parents had ever had an operation requiring intubation, nor had they been tested. The third brother had not been tested, though there was no reported problem with anesthesia during his operation for pyloric stenosis.

The patient was given pneumococcal vaccine the day of

admission. The next morning, he underwent a staging laparotomy without complications. Induction of anesthesia was accomplished with vecuronium. Nine separate lymph node sites, the spleen and biopsies of the right and left lobes of the liver revealed no evidence of Hodgkin's lymphoma. The final stage was IIA. After an uncomplicated hospital course, the patient was discharged on the sixth postoperative day.

## Discussion

The etiology of Hodgkin's lymphoma is unknown. Both environmental and genetic factors have been implicated. Family studies have shown Hodgkin's lymphoma in siblings, cousins, parents and children of affected patients, as well as in colleagues at work, teacher-student pairs, drug addicts, neighbors and spouses. Hodgkin's lymphoma has been described in association with other disease states including Epstein-Barr virus infection and hereditary spinocerebellar ataxia.<sup>15</sup>

Much research recently has focused on cytogenetic abnormalities in Hodgkin's lymphoma. Gain or loss of individual chromosomes

is common and has been described for all chromosomes, with the exception of chromosome three. Interestingly, loss of chromosome three was not observed in two large studies.<sup>6,7</sup> Structural abnormalities have been described in all chromosomes, with rearrangements involving 3q26-28, 6q15-16, 7q31-35, 12p11-13 and 13p11-13 occurring in more than 20% of cases in one series.<sup>7</sup> These abnormalities are confined to the Reed-Sternberg cells.<sup>6</sup>

At the submicroscopic level, individual genes and gene products have been studied in Hodgkin's lymphoma. Initially, there was enthusiasm that the t(14;18) (q32;q21) translocation of follicular, non-Hodgkin's lymphoma was associated with Hodgkin's lymphoma. This translocation fuses the immunoglobulin heavy-chain joining region at 14q32 to the candidate oncogene bcl-2 at 18q21.<sup>8</sup> Subsequent work by the same authors, however, casts doubt on the

importance of this translocation.<sup>9</sup> Abnormal expression of the antioncogene p53 has been observed in neoplastic cells of Hodgkin's disease. This gene resides at 17p13 and abnormalities of its expression have been demonstrated in a number of human malignancies.<sup>10</sup> Finally, deletions within the Epstein-Barr virus latent membrane protein-1 (LMP1) gene have been found in those diagnostic Hodgkin and Reed-Sternberg cells that express the LMP1 protein. This deletion appears to correlate with histologically aggressive behavior.<sup>11</sup>

Pseudocholinesterase is an enzyme found in the plasma that hydrolyzes the depolarizing muscle relaxant succinylcholine. Clinically, pseudocholinesterase influences the duration of action of succinylcholine by controlling the rate at which the latter is hydrolyzed.<sup>12</sup> The gene for pseudocholinesterase is found on chromosome three.

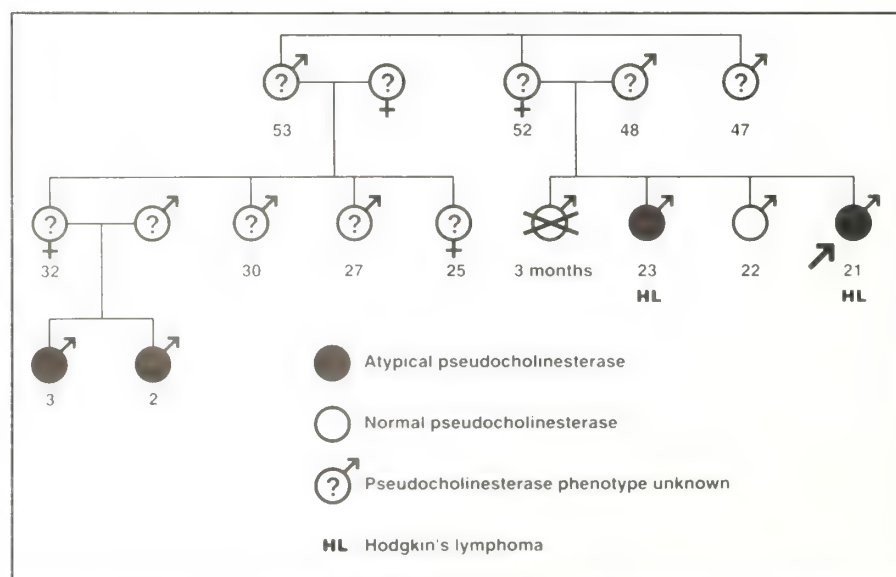
Genetically defined variants of

pseudocholinesterase have been discovered that can prolong neuromuscular blockade by succinylcholine. These variants are categorized by sensitivity to the inhibitors dibucaine and fluoride.<sup>12</sup> Four autosomal alleles have been described and are designated E<sub>1</sub><sup>u</sup> (usual), E<sub>1</sub><sup>a</sup> (detected by dibucaine), E<sub>1</sub><sup>f</sup> (detected by fluoride) and E<sub>1</sub><sup>s</sup> (silent). The locus of these alleles is at 3q25.2.<sup>3</sup> Atypical pseudocholinesterase has been described in association with the autosomal recessive Sanfilippo's syndrome.<sup>13</sup>

To our knowledge, no association between Hodgkin's lymphoma and atypical pseudocholinesterase has previously been described. The spontaneous occurrence of these two uncommon conditions occurring in a single patient is unlikely. The statistic probability of both conditions occurring in two brothers, though, is quite low. Because we could find no chromosomal abnormality, we conclude that this association between Hodgkin's lymphoma and atypical pseudocholinesterase in two brothers most likely represents a fortuitous coincidence, though it does not exclude a genetic link between Hodgkin's lymphoma and chromosome three at the submicroscopic level. □

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Figure

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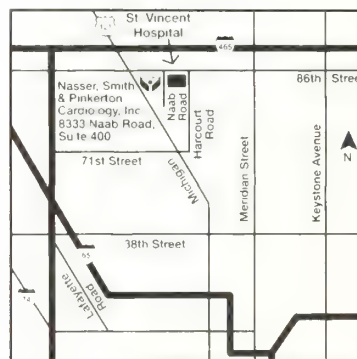


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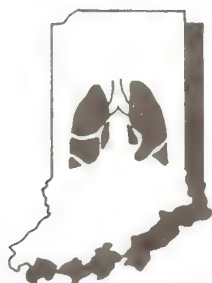
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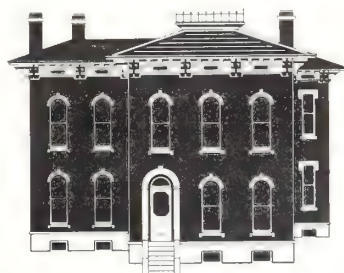
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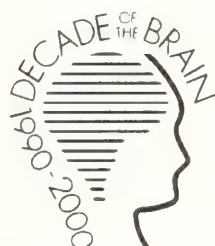
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## Physician impressed by legislator's dedication

**Paula A. Hall, M.D.**  
Indianapolis

*Editor's note: This column features excerpts from an article reprinted with permission from the Indianapolis Medical Society Bulletin.*

On March 9, I participated in the "Walk in the Shoes of a Legislator for a Day" Alliance program. It was quite an eye opener! I followed, although I have to admit it felt more like chased, Sen. Pat Miller around for the day. We started out at what I considered a rather leisure pace at 8:45 a.m. Of course, before I had time to get too smug about how late we were starting, I found out that she had already attended a 7 a.m. breakfast and given a speech. First stop was the Finance Committee, where we heard testimony and voted several bills out of committee.

... We stepped out briefly to attend a special meeting with a constituent, the president pro tem of the Senate, the constituent's representative and the director of Medicaid in Indiana.

Next, we ran back to the Finance Committee and listened to more testimony. When that finished, we ran to a committee meeting to discuss how zoning laws can be better crafted so that fast food restaurants won't be constructed in the middle of neighborhoods.

We left that meeting early so that we could meet with the governor and a bipartisan group of senators and representatives to discuss welfare. I was amazed at their sincere desire to form legislation that was in the children's and the state's best interest. The

legislators were all interested in passing a bill that got and kept people off welfare, but not to the detriment of the children or the taxpayers.

From that meeting, we went to her work station. I call it that because it really isn't an office because it is not large enough or in the least bit private. She took her messages and rushed off to the Senate for the roll call.

After the Senate was recessed, she stepped out into the hall to give the lobbyists a chance at her. She was polite and really listened to them when they were explaining their side of an environmental issue. We then went to a subcommittee on finance and listened to a long testimony on mental health.

By 4 p.m. we ended back in her work station. This was actually

the first time all day that we were able to talk.

I enjoyed my day at the legislature. What struck me the most was the calling that one must have to be such a public servant. It, I suppose, is the same type of calling that one has for medicine. I am sure that legislators, like physicians, have varying degrees of dedication. No one should doubt Sen. Pat Miller's calling. Her knowledge on a wide variety of issues was astounding. She was always polite, but she did not let politeness get in the way of progress.

The thought that kept running through my mind was "this is a lady with a lot of chutzpah," and I sure am glad that she is the chairman of the Health and Environmental Affairs Committee. □

## Convention at a glance

The 51st ISMA Alliance Annual Convention will be held Oct. 19 through 21 at the Radisson Hotel in Indianapolis. A brief overview follows:

### Thursday, Oct. 19:

- 1 p.m. Registration; convention commencement.
- 3 p.m. Outgoing and incoming board of directors meeting; Sharon Scott, AMA Alliance president, speaking.

### Friday, Oct. 20:

- 9 a.m. ISMA House of Delegates opening session; report from ISMA Alliance president.
- 11 a.m. ISMA Alliance House of Delegates opening session.
- 12:30 p.m. Sharon Scott, AMA Alliance president, speaker
- 5:30 p.m. Social hour (lobby level).
- 6 p.m. Dinner honoring Ann Wrenn, AMA Alliance secretary; Clifford Kuhn, M.D., a Louisville psychiatrist, speaker. Afterglow reception honoring incoming ISMA Alliance President Valerie Gates; Western line dancing with Don and Judy Massey - back by popular demand.

### Saturday, Oct. 21:

- 8 a.m. Breakfast fashion show sponsored by Parisian department store.
- 10 a.m. House of Delegates; installation of officers.

A convention brochure will be mailed to all ISMA Alliance members in August. □

## ■ from the museum

Oren Cooley  
Indianapolis

The library at the Indiana Medical History Museum contains books, pamphlets and illustrations that reflect the diverse treatments espoused by various medical philosophies during the late 1800s and early 1900s.

Physicians at the turn of the century, for example, were discussing the appropriate treatment for pneumonia and the ramifications of this disease. Allopathic physicians recommended that a "patient suffering from pneumonia should be put to bed in a well ventilated room ... [and] not be allowed to ... get up until after the crisis has occurred," according to an article that appeared in the *Transactions of the Indiana State Medical Society* in 1901. "The importance of maintaining absolute rest is obvious when one considers that one of the chief factors in the outcome of the disease is whether the heart will withstand the intense strain placed upon it [by the disease]."

Besides absolute rest, the allopathic treatment included liquid nourishment (such as broth), temperature reduction (usually by applying cold packs), careful monitoring of the heart and, if necessary, subsequent treatments to support the heart. In the worst cases of pneumonia, physicians typically administered either strychnine, alcohol, ammonia compounds or nitroglycerin to assist the heart.

In addition to allopathic physicians, Indiana also had medical practitioners who followed the tenets of homeopathy and hydropathy as well.

Homeopathic physicians

maintained that a person may cure a disease or its symptoms by ingesting drugs that produce similar symptoms in a healthy body. This theory also stated that taking infinitely small doses of a drug may heighten its effect.

According to *Our Family Physician* (1885), homeopaths recommended that one begin treatment of pneumonia by giving the patient aconite alone or in alternating doses with either Bryonia or belladonna if the fever remained high and the chest pain severe.

In contrast, hydropathic physicians proposed that water worked most effectively as a healing agent when administered gradually through the skin, a process they termed

"transduction." Although a practitioner could use different applicators, a hydropath typically used sheets to administer the required treatments.

Physicians may visit the historic library at the Indiana Medical History Museum to discover more about how illnesses were treated during the late 1800s and early 1900s. The museum, located at 3045 W. Vermont St., Indianapolis, is open from 10 a.m. to 4 p.m., Wednesday through Saturday. For more information, call the Indiana Medical History Museum at (317) 635-7329. □

*The author is director of the Indiana Medical History Museum in Indianapolis.*



The library at the Indiana Medical History Museum, depicted here at the turn of the century, contains more than 3,000 volumes on the different fields of medicine.



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## **St. Vincent Hospitals**

St. Vincent Hospital and Health Services will present the following CME courses:

- Aug. 23** - Practice Management Seminar, The Ritz Charles, Indianapolis.
- Sept. 15** - ATL Course, St. Vincent Marten House, Indianapolis.
- Sept. 28-Oct. 1** - Ninth International Congress on Ultrasound Examination of the Breast, site to be announced, Indianapolis.
- Nov. 3** - Emergency Room Physicians Seminar, The Ritz Charles, Indianapolis

For more information, call Beth Hartauer, (317) 338-3460.

## **Indiana University**

The Indiana University School of Medicine will present the following CME courses:

- Sept. 9** - Cost-Effectiveness of Neurological Investigations.
- Sept. 10-12** - High-Risk Infant and Neonatal Nutrition Conference.
- Sept. 15** - The Palliative Treatment Strategies for

Lung and Esophageal Cancer.

- Sept. 22-23** - 18th Annual Midwest Glaucoma Society Meeting - Glaucoma: Making Good Decisions.

- Sept. 29-30** - Management of Low Back Pain for the Primary Care Physician, Holiday Inn Crowne Plaza (Union Station), Indianapolis.

- Oct. 25** - Update on the Management of HIV Infection.

- Nov. 3** - Breast Cancer 1995, Clinical Controversies and Management.

- Nov. 11** - Fifth Annual Trauma/Surgical Critical Care Symposium.

All courses will be held at the University Place Conference Center and Hotel in Indianapolis, unless otherwise noted. For more information, call (317) 274-8353.

## **University of Wisconsin**

The University of Wisconsin Medical School will sponsor the Chronic Pain Conference Oct. 13 and 14 at the Holiday Inn - West in Madison, Wis.

All health professionals whose patients suffer from chronic pain are encouraged to attend. For more information, call Sarah Aslakson, (608) 263-2856.

## **University of Michigan**

The University of Michigan Medical School will sponsor these CME courses:

- Aug. 4-6** - Endocrinology and

Diabetes Update, Grand Traverse Resort, Grand Traverse Village, Mich.

- Sept. 5-6** - Advances in Body CT and MRI.

- Sept. 6** - Radiologic Technologist Program.

- Sept. 7-8** - 17th Annual Seminar in Diagnostic Ultrasound.

- Sept. 11-16** - Pediatric Board Review.

- Sept. 18-19** - Update on Pulmonary and Critical Care Medicine.

- Sept. 27-28** - Office Procedures for Primary Care Physicians Seventh Annual Workshop Course.

- Oct. 19-21** - Seventh Annual Modern Perinatal Problems.

All courses will be held at The Towsley Center, University of Michigan, in Ann Arbor unless otherwise listed. For registration information, call Vivian Woods at (313) 763-1400. □

## **How to submit CME news**

To publish news of your CME courses, mail information to *Indiana Medicine*, 322 Canal Walk, Indianapolis, IN 46202-3268 or fax it to (317) 261-2076. News is due two months before publication (e.g., July 20 for the September/October issue). □

## ■ news briefs

### **Riley Hospital verified as Level I trauma center**

Riley Hospital for Children in Indianapolis has been verified as a Level I Regional Pediatric Trauma Center, the first and only verified site in Indiana. Fewer than 10 pediatric Level I institutions have been verified nationally.

Level I verification is granted by the American College of Surgeons and is based on the availability of comprehensive pediatric trauma services provided by Riley, Wishard Memorial and Lifelines Children's hospitals. Riley relies on emergency room services at Wishard for the triage of critically injured patients from throughout Indiana. Riley patients receive rehabilitation services when necessary at Lifelines.

The American College of Surgeons has defined injuries that require Level I care as "immediately life threatening."

### **IU Cancer Center receives research grant**

Indiana University Cancer Center, which developed the world's first drug therapy to cure testicular cancer, has received a \$500,000 Bristol-Myers Squibb Unrestricted Cancer Research Grant. The funding will aid the university's search for the causes of cancer and the development of effective therapies.

The five-year, no-strings attached grant furthers the longstanding partnership between Bristol-Myers Squibb and Indiana University.

The cancer center is part of the IU Medical Center in Indianapolis.

### **IU Medical Center chosen as one of best U.S. hospitals**

Indiana University Medical Center appears in the second edition of

### **Search underway for new IU School of Medicine dean**

**W**alter J. Daly, M.D., dean of the Indiana University School of Medicine, recently announced that he will retire later this year. He completes a 12-year tenure as dean.

Because of the number and size of the constituencies that support the programs of the school, a small search and screen committee and a separate advisory committee have been appointed to help select a successor to Dr. Daly. Both committees will play central roles in the search and screen process, and both will be chaired by Joe C. Christian, M.D., Ph.D., professor and chair of medical and molecular genetics.

The committees will welcome names of applicants and nominees for the deanship position. Physicians in Indiana can submit names and recommendations to Joe C. Christian, M.D., Ph.D., Chairman, Medical and Molecular Genetics, Indiana University School of Medicine, 975 W. Walnut, Room 130, Indianapolis, IN 46202. □

*The Best Hospitals in America*, published earlier this year by Gale Research, Inc. The guide provides assistance to health care consumers by "identifying hospitals and medical centers whose special qualities have earned them the highest standing in the medical community."

Gale Research sought recommendations from physicians across the country and researched government sources and professional and popular publications to make their selections. Surveys and interviews with about 150 hospitals were conducted in an effort to help the general public locate outstanding treatment centers for any serious illness. Criteria were based on the "needs and concerns of patients," and in all cases the recommended hospitals are referral centers for critically ill and injured patients.

### **Midwest Eye Institute has two locations**

Midwest Eye Institute has opened a second office. The newest office is located at 201 Pennsylvania Parkway in Indianapolis, off Meridian Street at I-465 on the city's northside. The original office at located at 1800 N. Capitol in Indianapolis.

The institute receives patients upon referral to handle subspecialty problems.

### **NIH offers free report on total hip replacement**

A National Institutes of Health (NIH) consensus development statement on total hip replacement is available from the NIH Office of Medical Applications of Research.

Prepared by a panel of experts who considered scientific evidence presented at a consensus development conference, the report contains recommendations and conclusions about total hip re-

placement.

Free, single copies of the report are available from William H. Hall, Director of Communications, Office of Medical Applications of Research, National Institutes of Health, Federal Building, Room 618, 7550 Wisconsin Ave., MSC 9120, Bethesda, MD 20892-9120, (301) 496-1143.

### AMA plans 1996 meeting on physician health

"Uncertain Times: Preventing Illness, Promoting Wellness" is the theme of the 1996 International Conference on Physician Health to be held Feb. 7-10 at the Sheraton San Marcos Hotel in Chandler, Ariz. The AMA is sponsoring the event.

Topics will include stress and physician health, the effects of violence directed at physicians, violence occurring within physicians' families, patient exploitation, substance abuse, physical illness and disability and physician well-being and family functioning.

For more information or to request an abstract submission form, call Elaine Tejcek, (312) 464-5066 or fax (312) 464-5841.

### Hospital and health care mergers, affiliations

This list, which will be a regular feature in *Indiana Medicine*, briefly summarizes recent news of mergers, acquisitions and affiliations of hospitals and other medical institutions. The information is reprinted from *Indiana Economic Log* with permission of NBD Bank, which compiles the list from newspaper stories.

- The seven physicians who owned the Women's Clinic in Lafayette have sold the business operations to Home Hospital's parent company.

- Huntington Memorial Hospital has decided to join the Fort Wayne-based Parkview Health System. Huntington County officials voted to convert Huntington Memorial to a non-profit, community-based hospital in order to join the Parkview System, anchored by Fort Wayne's Parkview Memorial Hospital.

- The sale of Lutheran Hospital in Fort Wayne has been approved by Lutheran congregations, and a definitive agreement has been signed with its purchaser, Tennessee-based Quorum Health Group, Inc. When the sale is complete, Lutheran will become the first for-profit hospital in Fort

Wayne.

- Culver Union Hospital in Crawfordsville is part of the new Tenet Healthcare Corp., created when California-based National Medical Enterprises Inc. acquired American Medical International Inc. The new Tenet Healthcare has 83 acute care hospitals in 13 states and four countries. □

### About the cover

The herb drying house at the country home of Vicki and Woody Atwood of Bargersville is the setting for this month's cover photo. Herbs such as rosemary, growing as topiaries in the terra cotta pots, and chamomile, lying on the table, have been used to treat illness in some cultures for centuries. Herbal remedies are a form of alternative or unconventional medicine, which is discussed in the feature article on page 256. Opinion pieces on unconventional medicine are on pages 244, 246 and 266. □



## ■ obituaries

### **Robert C. Bolin, M.D.**

Dr. Bolin, 70, a retired Lafayette internist, died March 16, 1995.

He was a 1946 graduate of the University of Utah College of Medicine and was a U.S. Army veteran.

Dr. Bolin, who practiced in Lafayette from 1954 until his retirement in 1994, was on the staff at the Arnett Clinic, where he served as president for many years. He was on the staff of St. Elizabeth Hospital Medical Center and Home Hospital. Dr. Bolin had served as president of the Tippecanoe County Medical Society and the Greater Lafayette Chamber of Commerce. He was a member of the American College of Physicians and Surgeons.

### **Paul V. Chivington Jr., M.D.**

Dr. Chivington, 72, an Indianapolis dermatologist, died April 27, 1995.

He was a 1945 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Chivington was on the medical staff of Wishard Memorial Hospital from 1954 to 1976, serving as chairman of the department of dermatology the last six years. He was an assistant clinical professor in dermatology at the Indiana University School of Medicine and was attending physician in the dermatology clinic at Riley Hospital for 22 years, retiring in 1976. He was a consultant at Hawley Army Hospital at Fort Benjamin Harrison for 35 years and at the Walker Research Clinic from 1988 to 1990.

### **Gail E. Eldridge, M.D.**

Dr. Eldridge, 77, a retired Indianapolis family practice physician, died May 9, 1995.

He was a 1942 graduate of the

Indiana University School of Medicine and an Army veteran of World War II and the Korean War.

Dr. Eldridge had been in practice more than 50 years.

### **Arthur N. Larson, M.D.**

Dr. Larson, 68, a retired Elkhart general practitioner, died April 9, 1995.

He was a 1954 graduate of the University of Minnesota Medical School.

Dr. Larson was affiliated with the Dunlap Urgent Care Center. He was a fellow of the American College of Surgeons. Before coming to Elkhart in 1986, he had worked in the Federated States of Micronesia.

### **Ralph J. McQuiston, M.D.**

Dr. McQuiston, 89, a retired Indianapolis otorhinolaryngologist, died March 22, 1995, at The Forum Healthcare Center in Indianapolis.

He was a 1932 graduate of the Indiana University School of Medicine and served as an Army flight surgeon during World War II.

Dr. McQuiston was in practice for 50 years, retiring in 1984. He was professor emeritus at the IU School of Medicine, where he taught 15 years, and had served as chairman of the credentials committee of the American College of Surgeons. Dr. McQuiston was honored by three Indiana governors; he received a Citation for Meritorious Service in 1956, was named a Sagamore of the Wabash in 1967 and was recognized as a Distinguished Hoosier in 1971.

### **Donald C. Miller, M.D.**

Dr. Miller, 68, a Cedar Lake family practice physician, died Feb. 27,

1995, at St. Anthony Medical Center in Crown Point.

He was a 1950 graduate of the Indiana University School of Medicine and served with the U.S. Navy during World War II and as a Naval flight surgeon during the Korean War.

Dr. Miller, who had a family practice in Cedar Lake for 35 years, was a member of the staff at St. Anthony Medical Center. He was a member of the American Academy of Family Physicians.

### **Douglas C. Offutt, M.D.**

Dr. Offutt, 52, a retired Evansville internist, died April 29, 1995, at his home.

He was a 1975 graduate of the Indiana University School of Medicine.

Dr. Offutt worked with George Wilson, M.D., and Associates since 1978 and had served on the staff of St. Mary's Medical Center. He retired in 1994.

### **Everett C. Taylor, M.D.**

Dr. Taylor, 90, formerly of Upland, died March 26, 1995, in Jefferson City, Tenn.

He was a 1931 graduate of the Indiana University School of Medicine.

Dr. Taylor was a family practice physician in the Upland area for more than 50 years, retiring several years ago.

### **Harry D. Tunnell III, M.D.**

Dr. Tunnell, 65, a Fort Wayne surgeon, died April 6, 1995, at Parkview Memorial Hospital.

He was a 1955 graduate of the Howard University College of Medicine.

Dr. Tunnell had practiced in Fort Wayne since 1968. He was a past president of the Allen County Cancer Society and of the Heart

Association of Indiana and a past board member of Blue Shield of Indiana and Omega Si-Phi Fraternity.

**Edmund L. Van Buskirk, M.D.**

Dr. Van Buskirk, 87, a Lafayette ophthalmologist, died April 29, 1995.

He was a 1933 graduate of the Indiana University School of Medicine.

Dr. Van Buskirk had been affiliated with the Lafayette Eye Center since 1991 and previously owned a practice for 14 years. He was a senior physician at the Arnett Clinic from 1936 to 1977 and had served as chairman of the division of ophthalmology and the department of surgery at St. Elizabeth Hospital and Lafayette Home Hospital. He had been president of the St. Elizabeth

Hospital medical staff and the Arnett Clinic and Hospital. Dr. Van Buskirk was a fellow of the American Academy of Ophthalmology and the American College of Surgeons, a past president of the Indiana Academy of Ophthalmology and a member of the board of directors of the Indiana Medical History Museum. □

**Dr. Hugh C. Hendrie**, chairman of the department of psychiatry at the Indiana University School of Medicine, was named president-elect of the American Association for Geriatric Psychiatry.

**Dr. Eric N. Prystowsky** of Northside Cardiology in Indianapolis was co-chairman of the International Symposium, ICD Therapy: 15 Years' Experience and Future Expectations, in Paris, France.

**Dr. Scott M. Sharp** of Southside Cardiology, a division of Northside Cardiology in Indianapolis, was co-author of an article titled "Dobutamine Stress Echocardiography: Detection of Coronary Artery Disease in Patients with Dilated Cardiomyopathy" published by the American College of Cardiology.

**Dr. Borys Surawicz** of Nasser, Smith & Pinkerton Cardiology in Indianapolis spoke on "Present Status of Pharmacologic Treatment of Cardiac Arrhythmias" at the Alpe-Adria Association of Cardiology in Budapest, Hungary.

**Dr. Nancy A. Branyas** of Nasser, Smith & Pinkerton Cardiology in Indianapolis spoke on "Women and Heart Disease" at a meeting of the Association of University Women of Indiana in Indianapolis.

**Dr. Rick C. Sasso**, an orthopaedic surgeon with Indianapolis Neurosurgical, presented a paper at the annual meeting of the American Academy of Orthopaedic Surgeons in Orlando, Fla.; the title of his presentation was "Occipito-cervical Fusion with Posterior Plate and Screw Instrumentation: A Long-Term Follow-up Study."

### Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

#### March 1995

Aeschliman, William J., Fort Wayne  
Allen, Deborah I., Indianapolis  
Atkins, Clayton H., Greenwood  
Baker, Eldon E., Delphi  
Beck, Gary L., Evansville  
Boha, Maria A.S., New Albany  
Campbell, Betty J., Terre Haute  
Carey, John A., Gary  
Catinella, A. Peter, Indianapolis  
Clark, Diana L., Greenwood  
Clutter, Robert E., Indianapolis  
Cockrell, Dale K., Indianapolis  
Ferency, Alexander, Lafayette  
Ferree, Harry L., Indianapolis  
Fisher, Philip E., Granger  
Gomez, Cesar M., Hammond  
Haley, Alvin J., Indianapolis  
Harris, James J., Fort Wayne  
Harris, Thomas M., Floyds Knobs  
Haste, John L., Argos  
Heaton, Gregory E., Madison  
Hendricks, Fred A., Indianapolis  
Jamerson, Ronald E., Griffith  
Johnson, Robert D., Madison  
Jones, Thomas A., Indianapolis  
Kammeyer, William A., Fort Wayne  
Kolody, Diane M., Franklin  
Koopman, Anton J., Columbus  
Lee, Chung S., Fort Wayne  
Liebner, Michael S., Logansport  
Link, Charles W., Greenwood  
Malachowski, Robert M., Indianapolis  
Mc Laren, Daniel E., Indianapolis  
Mc Laughlin, David S., Indianapolis  
Myron, Stephen R., Portland  
Overley, Toner M., Indianapolis  
Peterson, John C., Muncie  
Ragsdale, Rex H., Evansville  
Randolph, Geoffrey M., Fort Wayne  
Richert, Charles L., Greenwood  
Ruckman, William P., Lafayette  
Scherschel, Kim P., Bedford  
Shah, Rekha B., Munster  
Snell, Alan D., South Bend  
Stene, Henry A., Greenwood

Trusler, Harold M., Indianapolis  
Van Buskirk, Edmund L., Lafayette  
Ward, Robert A., Tell City  
Wolf, Harry C., Indianapolis  
Young, Joseph W., Franklin

#### April 1995

Artis, Myrle E., Kokomo  
Brucker, Perry A., Fort Wayne  
Cespedes, Carlos A., Griffith  
Ehsan, Mohsen, New Albany  
Elliott, Edward F., Carmel  
Ferguson, James F., Bloomington  
Fetters, Clifford W., Noblesville  
Good, Richard L., Munster  
Haas, Ray A., Greenfield  
Harris, Charles M., Carmel  
Havlik, Robert J., Indianapolis  
Hehemann, William V., Munster  
Hunter, Robert E., Muncie  
Johnston, Philip E., Indianapolis  
Krishna, Gopal, Indianapolis  
LaFollette, James W., Bloomington  
Lucas, Owen H., Chesterton  
Maus, Ronald T., Kokomo  
McCormick, Charles O., Greenwood  
McGarvey, William K., Indianapolis  
Nonweiler, John T., Reelsville  
Oskarson, Oskar, Indianapolis  
Palmer, Barron M., Hammond  
Patel, Damyanti R., Anderson  
Powers, William R., Lyons  
Rahdert, Richard F., West Lafayette  
Ramos, Leonardo P., Jeffersonville  
Reidy, James E., Mishawaka  
Riley, Henry S., Madison  
Rustagi, Prevesh K., Fort Wayne  
Sharp, Gary C., Greenfield  
Siddell, James P., New Haven  
Snow, Daniel J., Scottsburg  
Streepy, Janet L., Munster  
Wilson, Jeffrey K., Kokomo  
Wyatt, Susan D., Logansport  
Zajac, Andrej J., Munster  
Zent, Don P., Kokomo □



**Dr. Marilyn J. Bull**, director of the section of developmental pediatrics at the Indiana University Medical Center, was named to a Blue Ribbon Panel of the National Highway Traffic Safety Administration. The panel was convened to facilitate more convenient and correct use of child safety seats and seek solutions to incompatibility concerns.

**Dr. Maurice E. Arregui** of Indianapolis was named chairman of the Learning Center for the 1996 World Congress in Endoscopic Surgery to be held in Philadelphia. Two books that Dr. Arregui edited or co-edited were recently published; they are *Minimal Access Coloproctology* and *Principles of Laparoscopic Surgery: Basic and Advanced Techniques*. He spoke on "Indications Based on Cost and Outcome for Laparoscopic Hernia Repairs," "Laparoscopic and Endoscopic Ultrasound" and "Hernia, Lymph Node Anatomy" at a SAGES postgraduate course and scientific session in Orlando, Fla.

**Dr. Douglas K. Rex** of the Indiana University Medical Center in Indianapolis received a research grant from the American College of Gastroenterology's Institute for Clinical Research and Education. His study will be on "Screening Colonoscopy Five Years After a Negative Examination in Asymptomatic Average-Risk Patients."

**Dr. Stephen W. Perkins**, an Indianapolis facial plastic and reconstructive surgeon, is the editor of the blepharoplasty volume of *Facial Plastic Clinics of North America*, accepted for publication in May. He also was the author of the volume's chapter titled "The Transconjunctival Approach to Lower Lid

Blepharoplasty." He wrote an article titled "Management of the Complications of Chemical Face Peeling" that will be published in the July 1995 issue of *Facial Plastic Journal*. He was a panelist for two workshops on chemical face peeling during the spring meeting of the American Academy of Facial Plastic and Reconstructive Surgery held in conjunction with the Combined Otolaryngological Societies meeting in Palm Desert, Calif.

**Dr. David A. Fisher** of Orthopaedics Indianapolis presented a poster titled "A Comparison of the Medial Trivector Approach to the Standard Medial Patellar Arthrotomy in Total Knee Arthroplasty" and a scientific exhibit on "The Effect of a Patient Management System on Outcomes of Total Hip and Knee Arthroplasty" at the annual meeting of the American Academy of Orthopaedic Surgeons. He presented a poster and paper on "The Effect of a Patient Management System on Outcomes of the Total Hip and Knee Arthroplasty" at the annual meeting of the Mid-America Orthopaedic Association.

**Dr. John K. Schneider** of Orthopaedics Indianapolis presented a program on "Orthopaedic Management of Pelvic and Acetabular Fractures" at the M.R. Medical College in Gulbarga, India.

**Dr. William H. Beeson**, an Indianapolis facial plastic and reconstructive surgeon, was the keynote speaker at the Greater Atlanta Otolaryngologic Society meeting; his topic was lasers in facial surgery. He spoke on his latest research on aesthetics of the forehead and brow at the American Academy of Facial Plastic and Reconstructive Surgery meeting in

Palm Desert, Calif. He lectured on blepharoplasty and aesthetic surgery of the upper face at a meeting of the American Academy of Dermatologic Surgery and Oncology in Hilton Head, S.C.

**Dr. Mark G. Evenson**, a Tipton anatomic and clinical pathologist, received a three-year appointment as cancer liaison physician for the hospital cancer program at Tipton County Memorial Hospital. The cancer liaison program is a part of the Commission on Cancer of the American College of Surgeons.

**Dr. Steven F. Isenberg**, an Indianapolis otorhinolaryngologist, will present a course on "Surviving as an Independent Practitioner" at the meeting of the American Academy of Otolaryngology-Head and Neck Surgery in New Orleans. At the same meeting he will present a poster on "Independent Otolaryngologists' Outcomes Survey of External Otitis Employing Confidential Self-Assessment of Quality" and a scientific exhibit titled "Meaningful Clinical Outcomes Utilizing Project Solo."

**Dr. Gerald M. Wohlfeld**, a New Albany radiologist, was honored by the South Central Indiana Association for the Handicapped for his service to the disabled.

**Dr. Maurice E. John**, a Jeffersonville ophthalmologist, presented a course on the treatment of hypermature cataracts at the meeting of the American Society of Cataract and Refractive Surgery in San Diego, Calif.

**Dr. Alvan L. Eller**, a Flora family practice physician, was honored at an open house for his 25 years of service in Flora.

**Dr. Robert D. Glassman**, a Danville cardiologist, was named

## ■ people

chief of staff at Hendricks Community Hospital.

**Dr. Jeffrey M. Blake** and **Dr. William E. Gist**, both of Anderson, have been certified by the American Board of Obstetrics and Gynecology.

**Dr. Lloyd W. Lempke**, a Lafayette orthopaedic surgeon, was honored at a retirement reception at St. Elizabeth Hospital Medical Center. He joined the hospital staff in 1966.

**Dr. Thomas J. Worster** of Bloomington has been certified in rheumatology by the American Board of Internal Medicine.

**Dr. Leonard J. Kibiloski** of Elkhart has been certified by the American Board of Orthopaedic Surgeons.

**Dr. James S. Robertson** has retired after 47 years as a family practice physician in Plymouth.

**Dr. Gregory E. Heaton**, an anatomic and clinical pathologist, was elected chief of staff at Dearborn County Hospital in Lawrenceburg. Other officers are **Dr. Jim D. Swanson**, an orthopaedic surgeon, chief of staff-elect, and **Dr. Arthur C. Jay**, a pathologist, secretary-treasurer.

**Dr. Kalen A. Carty-Kemker** of Salem has been certified by the American Board of Family Practice.

**Dr. Khalil G. Wakim**, a general and vascular surgeon, was named president of the medical staff of St. John's Health System in Anderson. Other officers are **Dr. Eric R. Retrum**, a radiologist, president-elect, and **Dr. William J. Kopp**, a family practice physician, chief of staff.

**Dr. Richard A. Kelty**, a family practice physician, was elected medical staff president at Parkview Memorial Hospital in Fort Wayne. Other officers are **Dr. David Sowden**, a thoracic sur-

geon, president-elect, and **Dr. Robert Godley**, a cardiologist, secretary-treasurer.

### New ISMA members

**Wallace A. Askew**, M.D., Jeffersonville, ophthalmology.

**Paul A. Bergfelder**, M.D., Richmond, internal medicine.

**Juergen Bertram**, M.D., Jeffersonville, oncology.

**George B. Bittar**, M.D., Terre Haute, cardiovascular diseases.

**Bashar M. Bouzo**, M.D., Rising Sun, pediatrics.

**Mary J. Boylan**, M.D., Merrillville, general surgery.

**Robert A. Bright**, M.D., Mishawaka, anatomic/clinical pathology.

**Herman Burgermeister**, M.D., Portland, general surgery.

**A. Peter Catinella**, M.D., Indianapolis, family practice.

**Howard J. Cheshire**, M.D., Terre Haute, cardiovascular diseases.

**Ryo S. Choi**, M.D., Indianapolis, occupational medicine.

**Naveed M. Chowhan**, M.D., New Albany, oncology.

**Maureen A. Cooper**, M.D., Indianapolis, hematology.

**Jack P. Covell**, M.D., Auburn, emergency medicine.

**John P. Cusack**, M.D., Martinsville, family practice.

**Holly B. Faust**, M.D., Indianapolis, dermatology.

**Robert J. Femia**, M.D., Fort Wayne, emergency medicine.

**Bruce L. Fisher**, M.D., Louisville, Ky., cardiovascular diseases.

**Darryl L. Fortson**, M.D., Gary, family practice.

**Nancy R. Frappier**, M.D., Kokomo, neurology.

**Lisette O. Garrett**, M.D., Indianapolis, pediatrics.

**David C. Gray**, M.D., Jasper, psychiatry.

**Scot E. Hagadorn**, M.D.,

Crawfordsville, anesthesiology.

**Cheryl A. Harris**, M.D., Columbus, pediatrics.

**Stefan Hasinski**, M.D., Indianapolis, endocrinology.

**Robert E. Holt**, M.D., Anderson, psychiatry.

**Mark R. Hurt**, M.D., Munster, diagnostic radiology.

**Hector E. Ibanez**, M.D., Indianapolis, ophthalmology.

**Paul D. Jarvis**, M.D., Batesville, urological surgery.

**Charles E. Kinsella**, M.D., Indianapolis, pulmonary diseases.

**Susan A. Koslow**, M.D., Terre Haute, diagnostic radiology.

**Stewart W. Kribs**, M.D., Indianapolis, diagnostic radiology.

**Susan Ksiazek**, M.D., Marion, ophthalmology.

**Pastor R. Llobet**, M.D., East Chicago, cardiovascular diseases.

**John F. Martig**, D.O., Portland, anesthesiology.

**J. Matthew Neal**, M.D., Muncie, endocrinology.

**Cory S. Neumann**, M.D., Logansport, family practice.

**Emmanuel O. Ojomo**, M.D., Gary, obstetrics and gynecology.

**Lawrence R. Poliner**, M.D., Terre Haute, cardiovascular diseases.

**Vincent Puccia**, M.D., Terre Haute, general surgery.

**Charles J. Rodman**, M.D., Anderson, thoracic surgery.

**Steve L. Rousseau**, M.D., Muncie, family practice.

**Robert M. Schaefer**, M.D., Wabash, obstetrics and gynecology.

**Homayoon Shidnia**, M.D., Indianapolis, radiation oncology.

**Thomas L. Sutula**, M.D., South Bend, family practice.

**Jeuti B. Wylde**, M.D., Charlestown, psychiatry.

**Gary A. Yurow**, M.D., Louisville, Ky., cardiovascular diseases. □





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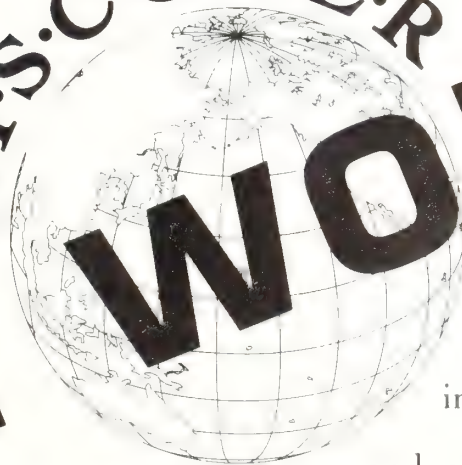
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M.D., Chairman, Department of Surgery, Indiana University School of Medicine, 545 Barnhill Dr., Room 244, Indianapolis, IN 46202.

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These medical plans have been specially designed for ISMA members and their employees to provide the highest quality coverage at the lowest possible cost. And, there is a special Claims Paying Unit for processing ISMA claims, with access through toll-free WATS lines. So take a look at the many plan options below and judge for yourself how your current coverage stacks up.

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<b>250</b>	<ul style="list-style-type: none"><li>\$250 calendar year deductible, \$500 per family</li><li>Stop-Loss limit \$5,000 per person, \$10,000 per family</li></ul>	✓	✓	✓
<b>500</b>	<ul style="list-style-type: none"><li>\$500 calendar year deductible, \$1,000 per family</li><li>Stop-Loss limit \$5,000 per person, \$10,000 per family</li></ul>	✓	✓	
<b>1,000</b>	<ul style="list-style-type: none"><li>\$1,000 calendar year deductible, \$2,000 per family</li><li>Stop-Loss limit \$5,000 per person, \$10,000 per family</li></ul>	✓	✓	
<b>2,000</b>	<ul style="list-style-type: none"><li>\$2,000 calendar year deductible, \$6,000 per family</li><li>Stop-Loss limit \$10,000 per person, \$30,000 per family</li></ul>	✓	✓	
<b>5,000</b>	<ul style="list-style-type: none"><li>\$5,000 calendar year deductible, \$15,000 per family</li><li>Stop-Loss limit \$25,000 per person, \$50,000 per family</li></ul>	✓	✓	

A PPN option is available with each plan and includes incentivized benefits when Premium Preferred Providers are utilized.

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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

September/October 1995

Vol. 88, No. 5



**John A. Knoté, M.D.**  
**AMA Vice Speaker**





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# INDIANA MEDICINE

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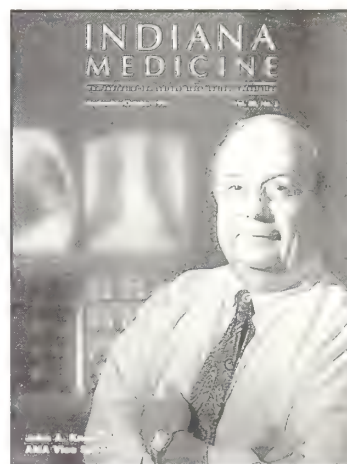
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## Indiana Supreme Court issues opinion on 'loss of chance'

The Indiana Supreme Court has issued an opinion that will allow juries to award damages in medical malpractice cases even if the patient was likely to suffer harm or death without the negligence. Under previous Indiana medical malpractice law, patients could recover for damages only if they could show that they would have had a better than 50% chance of surviving if the negligence had not occurred.

The recent Indiana Supreme Court ruling will allow juries to award damages if they believe that the malpractice was a "substantial factor" in causing the harm that the patient suffered.

This case involved a patient's death in 1990, claiming that a gynecologist's delay in detecting uterine cancer lessened the patient's chance to survive. By the time the patient's cancer was discovered, it was inoperable.

## Plan to attend ISMA's Jan. 17 legislative events

ISMA members can meet with their state legislators during the annual ISMA Medicine Day and the ISMA/IMPAC legislative reception Wednesday, Jan. 17, in Indianapolis.

Medicine Day activities will begin with a breakfast briefing by the ISMA legislative staff at the downtown Embassy Suites, followed by a visit to the Statehouse to meet with legislators. Physicians and legislators are invited to return to the Embassy Suites for lunch. Current Key Contact program participants and those interested in joining the program may attend the events. For more information, call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762.

The legislative reception will transport physicians and legislators to "The Golden Age of Hollywood." The event will be from 6 to 8:30 p.m. at the Hyatt Regency Hotel. Invitations will be mailed in December. For more information, call Susan Grant at the ISMA, (317) 261-2060 or 1-800-257-4762.

## ISMA program offers legal and financial advice

ISMA members can receive legal or financial advice at no charge by calling the ISMA Second Opinion program. To receive a referral, call Tim Brent at the ISMA, (317) 261-2060 or 1-800-257-4762. The initial phone calls to the ISMA and consultants are free for ISMA members. All inquiries will be kept confidential.

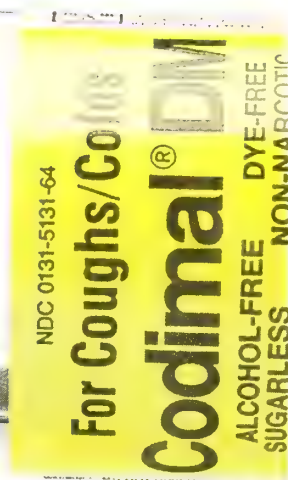
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## ■ letter to editor

### AMA vice speaker says thanks

Love of medical politics and dedication to the goals of a state comprise, as Vivian Priddy told Barney Maynard, M.D., a "terminal illness." Rest assured, the "disease" won't kill you, but you may indeed have "it" until death. Even though "afflicted," amazing things can sometimes be accomplished.

Earlier this year, your Indiana delegation to the American Medical Association and your ISMA staff put a short, stubby farm guy from central Indiana on their shoulders and carried him to the position of vice speaker of the House of Delegates of the AMA. The scope of their task was defined by negative comments from non-believers citing organizational logistics, timing and historical factors.

Your Indiana delegation and your ISMA staff (under the direction of John MacDougall, M.D., floor leader, on a foundation strengthened by former floor leader, Marvin Priddy, M.D.)

rolled up their sleeves, wore out their phones, burned up their word processors and fax machines, called in "chits" from their friends and in some cases prevailed upon their family and office staffs, and John Knoté was elected.

What will be the result of this monumental effort? We aren't certain as yet. We do know that the very effective work of your Indiana delegation and ISMA staff is recognized by others in the AMA. Through expanded opportunities for your representatives, Indiana philosophy will be more prominent in discussions at many levels within the AMA. Was it worth the time, effort and money? Those of us who were directly involved fervently believe that it was. Time will tell.

To the unbelievable Indiana delegation; to the marvelous ISMA staff; to the ISMA alliance; to the families of all involved; to many Indiana doctors outside the delegation who wrote letters; to the ISMA board of trustees; to Lowell Steen, M.D. (a previous

traveler on the road); to the many friends from other states who made a commitment; to my own family members (especially Margaret Knoté and the memory of Raymond Knoté); and to Jan, the woman beside the man, **your** AMA vice speaker says, "thank you till you're better paid." □

**John A. Knoté, M.D.**  
Lafayette

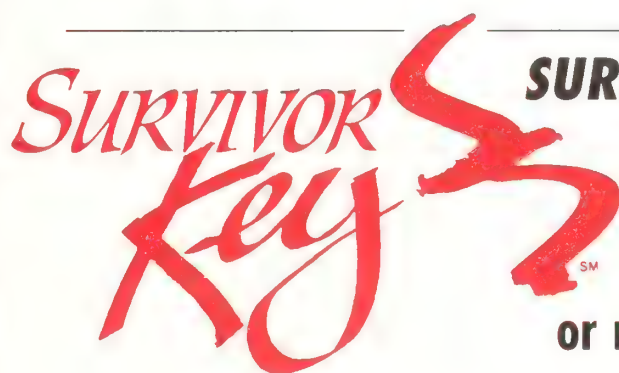
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# (K)noteworthy role:

Bob Carlson  
Indianapolis

Some days, when it looks as if medicine is going to hell in a handbasket, you wonder how much worse it would be if it weren't for the American Medical Association. Whatever twists and turns may lie ahead in this health care revolution, one thing's for sure – the AMA is a force to contend with.

One of the people who will be calling the shots at the AMA, and an articulate voice in the continuing health care delivery dialogue, is Lafayette radiologist John A. Knoté, M.D. On June 21, 1995, he was elected vice speaker of the AMA House of Delegates. One of four candidates for the post, Dr. Knoté was endorsed by the ISMA, the Indiana delegation to the AMA, the American College of Radiology and the Radiological Society of North America.

Dr. Knoté is on the staff of the Arnett Clinic and has practiced diagnostic radiology in Lafayette for 25 years. His involvement with the AMA dates back almost as far. He attended his first AMA interim meeting in the late 1970s and officially joined the Indiana delegation as president-elect and president of the ISMA in 1982 and 1983 respectively. He previously served as a trustee of the ISMA for six years and as chairman of the board of trustees for two years. He is a former member and chairman of the ISMA Commission on Legislation and the ISMA Future Planning Committee and served on the executive committee of the Physicians Insurance Company of Indiana.

Before being elected vice speaker, Dr. Knoté was in his second term on the AMA Council on Medical Service, where he

chaired the Subcommittee on Health Care Reform/Finance. He also was CMS representative to the Managed Care Forum and served on the Subcommittee on Managed Care and on the Convention Committee on Rules and Credentials. He is a member of the American Institute of Parliamentarians and serves on the board of the American Medical Speakers' Association.

He conducted the AMA Leadership Conference Health Care Reform Panel and the Forum for Medical Affairs breakout session at the Interim 1994 AMA House of Delegates meeting. His work in organized medicine includes leadership positions in the Organization of State Medical Association Presidents and in the American College of Radiology.

In this conversation with *Indiana Medicine*, Dr. Knoté briefly sketches his rise through the AMA ranks, talks about the major issues facing the AMA and describes what he'll be doing as the new vice speaker of the AMA House of Delegates.

**Indiana Medicine: Why did you decide to become involved in the AMA leadership?**

**Knoté:** Actually, I didn't decide to become involved in the leadership. I simply went to the annual and interim meetings of the American Medical Association, either as an officer, delegate or alternate, with the primary objective of representing the people from my state or professional society. The remainder of the House of Delegates and other leadership decide whether you're going to become involved in the leadership by voting for you or against you. If you go in search





# Serving as AMA vice speaker

of the position, you may not be as successful as if you go with the mission of presenting the views from your area, as well as perhaps some of your own views. At least in my case, it wasn't a decision to get involved and then pursuing a plan. It was simply going to represent the folks that sent us there either as officers or delegates and establishing good relationships with people in other delegations. If you're well accepted by the remainder of the delegates across the country, then you have an opportunity to become involved in the leadership.

**Indiana Medicine:** How long have you been involved as a representative in the Indiana delegation to the AMA?

**Knute:** I first got involved in the delegation when I was chairman of the ISMA board. I attended the interim meeting in the late 70's and then, of course, as president-elect in 1981-1982, and as president in 1982-1983, I was officially part of the [ISMA] delegation. After my year as past president, I became an alternate delegate for two years, in 1983 and 1984, and then in 1985 I became a delegate to the American Medical Association.

I also had the good fortune, shortly after becoming a delegate, to be selected president of the Organization of State Medical Association Presidents, and that gave me some exposure to people that were or would be either delegates or officers from their state. For the last five years, I've also been involved as a member of the Council on Medical Service. That's also an elected position. There are between nine and 11 members on each council. Some of

the councils are appointed by the board or the speaker and vice speaker, and some of them are elected. So that gave us at least two previous episodes of involvement in the election or campaign process at the AMA.

**Indiana Medicine:** What are the major issues facing the AMA these days?

**Knute:** The primary issue, of course, is the welfare of the patient and how we can deliver the best care to the patient. We won't forget that, and it will be our

“  
*A very real issue facing the AMA is allowing patients their own choice of physician and, of course, helping physicians retain choice of which patients they are able to see.*  
”

primary mission. Currently we are being asked to sort of mix that in with various payment considerations. A very real issue facing the AMA is allowing patients their own choice of physician and, of course, helping physicians retain choice of which patients they are able to see. I think beyond that, physician autonomy to give optimal patient care is a real consideration because some of the pre-paid situations that are developing now in some of the managed care operations seem to place

more emphasis on the fiscal aspect rather than on the medical care aspect.

**Indiana Medicine:** It sounds like managed care and the vertical integration that's happening in health care is really the one big issue that the AMA and you as vice speaker seem to be concerned with.

**Knute:** It's certainly the overwhelming issue in California, and as we all know, California is a bellwether state. It has for many years been a harbinger of things to come, whether good or bad. We're currently seeing situations in which groups of patients are being bought and sold and traded around amongst managed care entities. Furthermore, physicians are being bought and sold, in a sense, or being released from their responsibilities as the management of the managed care groups decides that their fiscal performance is not satisfactory.

Now, on the other hand, of course, there are managed care systems that are very successful, that give good patient care and in which many physicians want to participate. The crux of the matter from the AMA standpoint, in my opinion, is helping physicians, patients and all concerned to learn and to communicate the types of things that make medical care delivery work well, part of which may be managed care, and to help promote that, and to help decrease the types of approaches, whether it's managed care or fee-for-service, that don't work well. There are many situations in which fee-for-service still works well, and there are many situations in which grouping patients for

payment and management by other people may work well.

**Indiana Medicine:** Could I ask you to shift your focus on this topic to what's going on in Indiana these days?

**Knote:** In Indiana, perhaps more in the metropolitan areas where there's some pressure from employment groups, industry and business to reduce costs, we're seeing these managed care groups or systems being formed. In many instances, we have physicians, on the one hand, not being comfortable with that setting, yet on the other hand, being willing to participate because they feel if they are excluded that they won't have an opportunity to treat the patients that they've been dealing with throughout their practice.

**Indiana Medicine:** Would you say that this is the overwhelming issue for the AMA at this time?

**Knote:** I believe that it is.

**Indiana Medicine:** Can you briefly touch on some of the other issues the AMA will be working on?

**Knote:** One other thing that people are not talking about right now that is the most serious long-range implication of the orientation toward bottom line-type medicine is the decrease in education and research that may well occur under some of these new plans. As we've seen in Great Britain, throughout Europe and certainly in Canada, the funding for research and education has decreased dramatically. The lack of emphasis on education and

research seems to be occurring with the emergence of greater fiscal orientation to medical care.

**Indiana Medicine:** What are the roles and the responsibilities of the speaker and vice speaker in addressing these issues?

**Knote:** The speaker and vice speaker work in tandem. When they're not in meetings, they spend a fair amount of their time together getting to know each other, getting to know something about the issues and sharing their impressions about how things should work. Basically, the speaker and vice speaker don't have a policy-making or philosophical role in the issues. The responsibility of the speaker and vice speaker is strictly to conduct the proceedings of the House in a fair and equitable fashion, to help the House of Delegates present the issues, to discuss them in an orderly fashion and to allow all the people an opportunity to have their say, whether it be on the floor of the



House of Delegates or in the reference committees. The speaker and vice speaker do not preside over the reference committees, but they frequently pass from one reference committee to another to get a feel for what the discussion is on the issues that are reported back to the House of Delegates by the reference committees.

**Indiana Medicine:** What can you contribute as vice speaker?

**Knote:** I have a good insight into the feelings of the individuals in the House. I have worked hard at getting to know individual members of the House of Delegates from all the states and from the specialties. I know a large percentage of them personally. That's really the strength that I can personally bring to that position – the knowledge about how individual people feel about the issues and helping them present that in an equitable fashion. My insight into their geographic and personal background is something that helps facilitate that.

**Indiana Medicine:** What is the length of your term as vice speaker?

**Knote:** The terms are only one year, so you have to run for the position again every year. Historically, the incumbent has not been opposed. The situation this time was one in which the vice speaker was moving up to the speaker's position. That left no incumbent in the vice speaker's position, so four of us became candidates for that position.

**Indiana Medicine:** How long would you be interested in being



**vice speaker? Is there a term limit?**

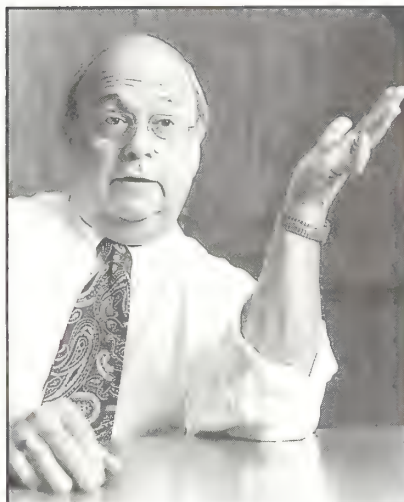
**Knote:** There isn't any limit, but typically, the vice speaker stays in that position until the speaker moves up. Historically, in the last 20 years, that has ranged between two to four years, with three years being the most common interval before the vice speaker moves up to another position.

**Indiana Medicine: What is the line of succession? The speaker moves up to what position, typically?**

**Knote:** This year, the speaker is Dr. Daniel Johnson, better known as Stormy Johnson from Louisiana, and he became the president-elect of the AMA. Historically, that has been something that's possible for the speaker to do.

**Indiana Medicine: How much time do you think you'll be contributing to this position?**

**Knote:** Right now, the new people such as myself and two newly elected trustees will probably not have to spend a great deal of additional time. For example, I've been spending three-and-a-half-day weekends five or six times a year, including the annual and the interim meeting, of course, with the Council of Medical Service. Between now and the end of year, based on what I know about the schedule, I've had to add only six additional days to my time off. Now, the amount of time one spends in these positions is directly related to the speaking assignments or the assignments to represent the organization that one may get, and I understand that



increases over a period of time. I think they will take it easy on those of us who are new until we get our feet on the ground on this new level within the organization and become comfortable with how the board discussions are going. Once we have an understanding of the issues, we are not new people any longer and may receive more speaking assignments or assignments to represent the organization as our tenure increases in these offices.

As I move over to this vice speaker position, I will also become an *ex officio* member of the Council on Constitution and By-Laws. Dr. Shirley Khalouf, past president of the ISMA, is also on that council, having been elected last year. The speaker and I are *ex officio* members of that council, but it's a weekend meeting, so that doesn't really add to the time away from work.

**Indiana Medicine: What is the role of the AMA House of Delegates?**

**Knote:** The House of Delegates establishes policies for the American Medical Association. The Board of Trustees has the authority to interpret and enforce that policy and, on occasion, to make what might be called "emergency decisions" between meetings of the House of Delegates. We meet twice a year, once in June and once in late November or early December. This year, there were 87 reports and 233 resolutions. At these meetings, we go through those reports and resolutions and establish policy by voting these ideas either up or down.

**Indiana Medicine: What is the current structure or composition of the House of Delegates?**

**Knote:** The House of Delegates is comprised of delegates from the various states. California has the most with 27. Several of the small states have only one. Also over 80 specialty societies have a delegate.

**Indiana Medicine: What's the deciding factor there?**

**Knote:** The number of physicians in the state who are members of the AMA is the deciding factor. Then there are also representatives to the AMA that have full delegate privileges from the various specialty societies. For example, the American College of Radiology, in which I'm active, has a delegate and an alternate. Indiana has two specialty delegates at this time. Dr. George Rapp represents the American Orthopedic Association, and Dr. Paul Honan from Lebanon represents the Contact Lens Association of Ophthalmologists. The specialty delegates are elected at the discretion of that specialty,



and they may come from any state. The larger states usually have several, and some states don't have any. We're fortunate to have two here in Indiana because we're a relatively small state.

**Indiana Medicine: How does the AMA House of Delegates relate to the AMA Board of Trustees?**

**Knote:** The House of Delegates elects the Board of Trustees. They also elect the president-elect and the president. The trustees do not have a vote, by the way, in the House. The speaker and vice speaker retain a vote in the House, but they don't have a vote on the board. The speaker and the vice speaker are considered general officers of the board and of the AMA, and we have right of full discussion on the board, but we do not have a vote.

**Indiana Medicine: Do members of the Board of Trustees come**



**from the House?**

**Knote:** Yes, they have to be members of the House to be elected to the Board of Trustees.

**Indiana Medicine: What is the best way for Indiana physicians to communicate with you and the AMA leadership?**

**Knote:** They can communicate by telephone calls, mail or resolutions sent through the Indiana State Medical Association deliberation process at our annual meeting. All of us who are involved take a fair amount of pride in communicating with the members, and probably we wouldn't be in these positions if we didn't practice that fairly regularly.

**Indiana Medicine: How can organized medicine help physicians take more of a leadership role in determining the future of medicine?**

**Knote:** There are two areas where we need to really improve in both state and national organizations. One is to increase our effectiveness in communicating with the members, and another is to offer more opportunities for the various leadership exposures people might want to have. There's never been a time, at least in our modern history, where involvement by individual practitioners is more important than it is right now. That's because there's so much activity now involving medical practice and legislation. It's really intense, and sometimes it detracts from our day-to-day work. But if

we leave this to other people, I don't think they'd do it as well as we can. That's the main reason I'm involved.

People frequently feel they can't become involved because they don't have a large enough constituency. But Dr. Robert McAfee, the immediate past president of the AMA, comes from Maine, which is a one delegate state.

In our own situation, only one of the four vice speaker candidates, including myself, was from a state with more than eight delegates. So there's ample opportunity for people who have the interest to become involved. It takes a little while because you have to be voted into office, and to get the votes, people have to know who you are.

The way I got there was with a lot of help from a lot of people in Indiana, and particularly the very hard work of the Indiana delegation, including the delegates and alternate delegates, as well as the ISMA officers in attendance, and the marvelous input, unparalleled perhaps in the country, from our ISMA staff, specifically Susan Grant, Rick King, Mike Abrams and Adele Lash.

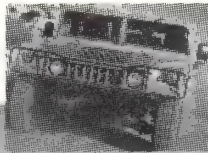
It's going to be fun. It's certainly exciting right now. Time will tell if we do our job or not, but we're going to give it a good shot. □

*In a letter on page 318, Dr. Knote thanks those who helped him in his successful campaign.*

---

*Bob Carlson is a health care writer based in Indianapolis.*

# HUMMER



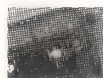
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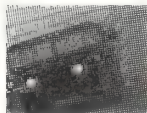
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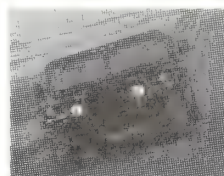


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# Managed care slowly makes inroads in Indiana

Thomas R. Neal  
Indianapolis

In all of the professions, major buyers of services, themselves major business organizations, are becoming more sophisticated in how they seek and pay for professional assistance. In medicine, corporate purchasers of services are requiring adherence to standards and controls and different payment mechanisms apart from simply paying hourly or procedural fees. All of this is a result of the pressure of time and money. The practitioner with resources will develop tools to enable him or her to provide the service faster and more accurately.

In answer to these sophisticated buyers, Indiana is developing a network of alliances and affiliations of individual practitioners, group practices, facilities and insurers. They are all jostling for position in order to bring to a negotiating table the panel of the best providers available at the lowest price to obtain the business they see developing across the table. No one now knows for sure what business will be negotiated across the table or when the parties will sit down together. However, no one wants to bet that the chairs will remain empty. In different areas around the country, the health service delivery business has developed in this way with remarkable speed. No one can tell, however, that Indiana will resemble southern California any time soon. Each area of the country has its own local politics and idiosyncrasies to account for. Indiana will develop its own

patterns of products and providers.

There are at least three statewide alliances forming to prepare for major contracts from the sophisticated purchasers. One is forming around Methodist Hospital in Indianapolis. Another is forming around St. Vincent/Community Hospitals of Indianapolis. Another is forming around physician practices acquired by financing through the Associated Group, successor to the Indiana "Blues." Regional hubs and pockets of employer coalitions are being formed throughout Indiana in areas of population concentration and the headquarters of major corporations. Whether all of these alliances will compete with each other, merge with each other or die on the vine remains to be seen. The solo family practitioner in central Indiana without external sponsor or employer is a rare commodity. Internal medicine looks to be going down the same path. Even sole community hospitals and rural county hospitals have acquired primary care practices as referral bases. Every hospital in Indiana either has or thinks it should have a PHO. Some of these PHOs are forming rings of alliances to make themselves into a network of hospitals and physicians. The breadth and scope of all of these alliances are limited only by the imagination and the powers of persuasion of their major cheerleaders. Antitrust laws also are supposed to have some influence.

Some of the more prominent alliances which are fairly well developed in Indiana are listed in this article. These lists are based

upon conversations and materials obtained from persons involved in the enterprises, but they are not represented here to be complete in all detail or still accurate on the date of publication. Some of these developments change weekly and monthly. As a whole, the alliances listed display a picture of a rapidly consolidating provider market.

On the other hand, the payer market, in the development of risk-based insurance products by various health plans or self-insured employers, is developing at a slower pace. It is one thing for a group of hospitals and physicians to sit down and agree to work together. It is another thing for a health care finance company to develop actuarially sound products, qualify them with the State Department of Insurance and sell them to actual customers who will use them.

Hoosiers are not quick to embrace novel ideas, especially when it comes to the care of their loved ones. Organized labor has not been quick to embrace what might be viewed as management's cost-cutting of their health benefits. Small employers and small groups of self-employed individuals have not had vehicles of organization or access to health plans which have major purchasing clout in the marketplace. Indiana is full of such examples. As a result of all of these factors, the managed care products in the Indiana marketplace which have capitated finance mechanisms or completely controlled delivery mechanisms are not the norm today. Ten percent to 15% of the marketplace may be represented by such products.



## HMO/health plan networks

### Alternative Health Delivery Systems

Clark  
Floyd  
Harrison  
Scott  
Washington

### American Health Network of Indiana, Inc.

All counties

### Anthem Health Plan of Indiana, Inc.

All counties

### Arnett HMO, Inc.

Benton  
Boone  
Carroll  
Cass  
Clinton  
Fountain  
Fulton  
Howard  
Jasper  
Miami  
Montgomery  
Newton  
Pulaski  
Putnam  
Tippecanoe  
Tipton  
Warren  
White

### CIGNA Health Care of Illinois, Inc.

Lake  
LaPorte  
Porter

### Health Maintenance of Indiana, Inc.

All counties except:  
Dearborn  
Franklin  
Ohio  
Switzerland  
Union

### Healthsource Indiana Managed Care Plan

All counties

### HMO Kentucky, Inc.

Clark  
Floyd  
Harrison  
Jefferson  
Scott  
Washington

### H Plan, Inc.

Boone  
Carroll  
Clark  
Fayette  
Floyd  
Franklin  
Grant  
Harrison  
Henry  
Jefferson  
Madison  
Marion  
Scott  
Shelby  
Spencer  
Washington

### Humana Health Plan, Inc.

Clark  
Crawford  
Floyd  
Harrison  
Jefferson  
Jennings  
Lake  
LaPorte  
Orange  
Porter  
Scott  
Washington

### Humana Health Chicago, Inc.

Lake  
LaPorte  
Porter

### M Plan, Inc.

Adams  
Allen  
Boone  
DeKalb  
Hamilton  
Hancock  
Hendricks  
Huntington  
Johnson  
Marion  
Morgan  
Noble  
Shelby  
Wells  
Whitley

### Maxicare Health Plans of the Midwest

All counties except:  
Benton  
Carroll  
Cass  
Clay  
Clinton

Fulton  
Greene  
Jackson  
Lawrence  
Martin  
Monroe  
Newton  
Orange  
Owen  
Parke  
Pulaski  
Putnam  
Tipton  
Washington  
White

### Maxicare Indiana, Inc.

All counties

### Metlife Healthcare Network of Kentucky Metlife Healthcare Network

Clark  
Floyd  
Harrison  
Lake  
Porter

### Midwest Independent Physicians Association

Dearborn  
Franklin  
Ohio  
Ripley  
Union

### Partners National Health Plans of Indiana, Inc.

Adams  
Allen  
Elkhart  
Huntington  
LaGrange  
LaPorte  
St. Joseph

### Physicians Health Network, Inc.

All counties

### Physicians Health Plan of Northern Indiana, Inc.

Adams  
Allen  
DeKalb  
Huntington  
Jay  
LaGrange  
Noble  
Steuben  
Wells  
Whitley

### Physicians Healthchoice, Inc.

Adams  
Allen  
DeKalb  
Huntington  
Jay  
LaGrange  
Noble  
Steuben  
Wells  
Whitley

### Principal Healthcare of Indiana, Inc.

Adams  
Allen  
Benton  
Boone  
Brown  
Cass  
Clinton  
Davies  
DeKalb  
Delaware  
Elkhart  
Fulton  
Grant  
Greene  
Hamilton  
Hancock  
Hendricks  
Henry  
Howard  
Huntington  
Jackson  
Jasper  
Johnson  
Kosciusko  
LaGrange  
Lake  
LaPorte  
Lawrence  
Madison

### Prudential Health Care Plan, Inc.

Boone  
Clinton  
Hamilton  
Hendricks  
Hancock  
Henry  
Johnson  
Lake  
LaPorte  
Madison  
Marion  
Montgomery  
Morgan  
Porter  
Putnam  
Shelby

### Rush Prudential HMO, Inc.

Lake  
LaPorte  
Porter

### Sagamore Health Network, Inc.

All counties

### Southeastern Indiana Health Organization

Bartholomew  
Brown  
Crawford  
Decatur  
Clark  
Dubois  
Floyd  
Harrison  
Jackson  
Jefferson  
Jennings  
Johnson  
Lawrence  
Monroe  
Morgan  
Orange  
Perry  
Ripley  
Scott  
Shelby  
Switzerland  
Washington

### Universal Health Services, Inc.

Clay  
Clark  
Dearborn  
Hancock  
Lake  
Madison  
Monroe  
Marion  
Porter  
Ripley  
Shelby  
Wayne

### Welborn Clinic/HMO/Health Options

Davies  
Dubois  
Gibson  
Knox  
Perry  
Pike  
Posey  
Spencer  
Vanderburgh  
Warrick

Listed in this article are the HMOs that currently are certified by the Indiana Department of Insurance to operate in the counties indicated. A number of these are relatively new in this state and have yet to market many new products aggressively. Additionally, each major provider alliance will have an HMO of its own to market risk products. Beyond that, the national HMOs are being qualified for business in Indiana and will market products of their own. Also included are four of the major employer initiatives in Indiana which combine large employers in a small geographic area with hospitals and physician groups to establish self-insured benefit plans with managed care controls. When the smaller employers begin to belong to such coalitions, the managed care products will achieve a higher market share.

Observers of the health care financing business often talk about four stages of managed care development in health care markets. The four generations or market types are characterized by certain accepted indicators. Indiana is moving into its second phase of maturity in its march toward managed care health services. The indicators of a second generation market are a moderate managed care penetration (above 20%) and a moderately fragmented payor base. In these markets, the providers are jointly pricing their services among hospitals and physicians and attempting consolidation for pricing along the continuum of health care. As the market matures to the third and fourth stages, higher levels of consolidations in the payers and in the providers occur.

## Hospital networks & multi-hospital systems

### Alliant Management Services/Health System

Blackford  
Clay  
Decatur  
Gibson  
Harrison  
Jay  
Jennings  
Perry  
Randolph  
Rush  
Warren

### Ancilla Health Systems

Allen  
Lake  
St. Joseph

Affiliations:  
Marshall

### Charter Hospitals

Allen  
Jefferson  
Lake  
LaPorte  
Marion  
St. Joseph  
Tippecanoe  
Vanderburgh  
Vigo

### Genesis Health Alliance (Daughters of Charity)

Daviess  
Dubois  
Gibson

Knox  
Perry  
Vanderburgh  
Warrick  
plus Illinois

### Holy Cross

Madison  
Marshall  
St. Joseph

### Memorial Health System

St. Joseph

Affiliations:  
Elkhart  
LaPorte

### Methodist

#### Six PAC hospitals:

Allen  
Bartholomew  
Marion  
Tippecanoe  
Vanderburgh  
Vigo

#### Affiliations/clinical

affiliations:  
Boone  
Delaware  
Huntington  
Johnson  
Lawrence  
Monroe  
Sullivan  
Tipton  
Wabash  
Whitley

### St. Francis Health Services

Lake  
LaPorte  
Marion  
Tippecanoe

### St. Vincent/Daughters of Charity

Hamilton  
Howard  
Madison  
Marion  
Morgan  
Vanderburgh

### Suburban hospitals

Boone  
Clinton  
Hamilton  
Hancock  
Hendricks  
Henry  
Johnson  
Marion  
Morgan  
Shelby

### TriState Healthcare Partners

Dubois  
Gibson  
Knox  
Pike  
Posey  
Spencer  
Vanderburgh  
Warrick  
plus Illinois and Kentucky

The fourth phase of the market is generally considered to be represented by managed care products of over 60% penetration, a highly consolidated payer base and capitated pricing for the service products. Whether this a five-year prediction for the Midwest and Indiana, in particular, is hard to say. The focus will have to

shift from provider consolidation to the payer consolidation. The provider side of the equation, though moving toward consolidation, will stay in flux for some time. Trial and error, or better described, dissatisfaction, will result in continued evolution of practice models and alliances. Physicians, hesitant at first,

## Physician practices

### American Health Network Practice

Boone  
Hamilton  
Hancock  
Hendricks  
Howard  
Johnson  
Marion  
Montgomery  
Morgan  
Tippecanoe

### Methodist Medical Group

Boone  
Hamilton  
Hancock  
Hendricks  
Howard  
Jackson  
Johnson  
Marion  
Morgan

Owen  
Shelby

### Northside Cardiology Practices

Bartholomew  
Cass  
Fayette  
Hamilton  
Howard  
Johnson  
Madison  
Marion  
Miami  
Pulaski  
Putnam  
Rush  
St. Joseph  
Tippecanoe

### Nasser, Smith, Pinkerton Cardiology Practices

Grant  
Hamilton

Hendricks  
Jennings  
Marion  
Vigo  
Wayne

### St. Vincent Physician Practices

Boone  
Cass  
Delaware  
Hamilton  
Hancock  
Howard  
Johnson  
Madison  
Marion  
Monroe  
Morgan  
Putnam

gradually should come into their own as the dominant factor in integrated systems. Organized by and through professionally compatible, self-governing structures, physicians should assume the leadership of the whole. Sooner or later, the public will demand it. □

*The author is an attorney with Krieg DeVault Alexander & Capehart. His practice includes corporate, reimbursement, medical staff, organizational and management issues for hospitals and physicians.*

## Employer coalitions

### Employer's Healthcare Coalition

Bartholomew  
Boone  
Delaware  
Hamilton  
Hancock  
Hendricks  
Howard  
Johnson  
Madison  
Marion  
Monroe  
Morgan  
Shelby

### Northwest Indiana Health Alliance

Lake  
LaPorte  
Porter

### Patoka Valley Cooperative

Crawford  
Daviess  
Dubois  
Martin  
Orange  
Perry  
Pike  
Spencer  
Warrick

### Southeast Indiana Health Organization

Bartholomew  
Brown  
Clark  
Crawford  
Decatur  
Floyd  
Harrison  
Jackson  
Jefferson  
Jennings  
Johnson  
Orange  
Ripley  
Scott  
Washington



# New prescription pads required for controlled drugs

Standard Register has been endorsed by the Indiana State Medical Association as the vendor for new prescription pads required for Schedule II, III, IV and V controlled drugs.

Beginning Jan. 1, 1996, all controlled substances prescriptions must be written on security paper, under a new rule passed by the Indiana Board of Pharmacy. The rule was passed in an effort to prevent prescription forgeries and controlled substance diversion.

The pads will be printed in blue ink on the front with a watermark stating Indiana Security Prescription on the back. Physicians may decide whether or not they want the DEA number preprinted on the form. If they choose not to have it pre-printed, they should stamp or manually print it on the prescription when writing controlled drugs.

The new rule requires the following:

- Security paper must be used on all controlled substances prescriptions and may be used on other prescriptions.
- Security paper must have a repetitive "void" pattern that appears when the paper is copied.
- The words "Indiana Security Prescription"

must appear in watermark form on the back of the paper.

- An RX symbol must appear in the prescription's upper right-hand side.
- Six quantity check-off boxes must be printed on the form.
- No advertisements may appear on the prescription blank.
- An individual, professional practice, professional association or hospital logo may appear in the upper left-hand side of the blank.
- Only one prescription per

blank is permitted.

- Refill options that can be circled must appear below any logo and above the signature lines.
- The prescriber's name and license number must be preprinted, stamped or manually printed on the prescription.
- The rule prohibits the names of controlled substances to be preprinted on the forms.

To order prescription pads from Standard Register, call 1-800-926-7806. □

**Possible  
Logo**

License Number

**Doctor Name**

Address

Address

Address

Telephone / Fax Number

Name \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_

- ☐ 1-24
- ☐ 25-49
- ☐ 50-74
- ☐ 75-100
- ☐ 101-150
- ☐ 151 and over

Refill NR 1 2 3 4 5 Void after \_\_\_\_\_

\_\_\_\_\_, M.D. \_\_\_\_\_, M.D.

Dispense as Written

May Substitute

Prescription is void if more than one (1) prescription is written per blank.

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Indiana  
State  
Medical  
Association

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146th ISMA Annual  
Convention & Exposition  
October 20-22, 1995  
Radisson Plaza & Suite Hotel  
Indianapolis

Shining The Light

On  
Managed  
Care



## Abridged schedule of convention events

### Thursday, Oct. 19

2:30 – 4:30 p.m. .... Board of Trustees meeting  
 6 – 7 p.m. .... Board of Trustees reception  
 7 – 9 p.m. .... Board of Trustees dinner

### Friday, Oct. 20

7 a.m. .... Trade show opening breakfast  
 9 a.m. .... House of Delegates, first session  
 11:30 a.m. .... Alliance luncheon  
 Noon .... Trade show luncheon in exhibit hall  
 1 p.m. .... Reference committees  
 6 p.m. .... Alliance reception/dinner  
 7 p.m. .... Afterglows

### Saturday, Oct. 21

8 a.m. .... PICI loss prevention seminar  
 10 a.m. .... Managed care panel discussion:  
                     The Changing Environment of  
                     Health Care Delivery  
 Noon .... IMPAC luncheon  
 2 p.m. .... Caucuses, free time  
 6 p.m. .... Presidents' Night reception  
 7 p.m. .... Presidents' Night Dinner and  
                     Dance

### Sunday, Oct. 22

7 a.m. .... Membership breakfast  
 9 a.m. .... House of Delegates, final session  
 Noon .... Board and executive committee  
                     organizational meetings □

## Official call

**T**he House of Delegates of the Indiana State Medical Association will convene at 9 a.m., EST, Friday, Oct. 20, 1995, at the Radisson Plaza & Suite Hotel in Indianapolis.

The House will reconvene for its second (final) session at 9 a.m. EST, Sunday, Oct. 22, 1995, at the Radisson Hotel.

Representation in the House for the 1995 annual meeting will be as follows:

Indianapolis – 40 delegates  
 Lake County – 15 delegates  
 Allen County – 12 delegates  
 Vanderburgh County – 9 delegates  
 St. Joseph County – 8 delegates  
 Delaware-Blackford, Monroe-Owen, Tippecanoe and Vigo-

Parke-Vermillion – 5 delegates each

Bartholomew-Brown, Elkhart, LaPorte, Madison, Porter and Wayne-Union counties – 3 delegates each

Clark, Daviess-Martin, Dearborn-Ohio, Fayette-Franklin, Floyd, Fountain-Warren, Grant, Harrison-Crawford, Howard, Jasper-Newton and Jefferson-Switzlerland – 2 delegates each

The remaining 53 county medical societies – 1 delegate each

Trustees -17  
 Past presidents – 20  
 Resident Medical Society – 1 delegate  
 Student Medical Society – 4 delegates

Total voting members of the House of Delegates – 239. □

## Presidents' Night Dinner and Dance scheduled

**T**he annual Presidents' Night Dinner and Dance will honor ISMA President William C. Cooper, M.D., and the incoming ISMA Alliance President Valerie Gates. A reception in the Plaza ballroom from 6 p.m. to 7 p.m. Saturday will begin the festivities, with dinner following.

Off Center will provide the musical entertainment for the dance.

Tickets are \$50 per person. □



## Panel to discuss managed care

**W**hat's really happening in the health care delivery system in Indiana? A panel discussion will "shine a light" on managed care from the national, state and local perspectives during a 10 a.m. session Saturday, Oct. 21.



**Dr. Weingarten**

managed care nationally.

His address will be followed

The keynote speaker is Scott Weingarten, M.D., M.P.H., director of health services research at Cedars-Sinai Medical Center in Los Angeles. Dr. Weingarten will discuss the status of



**Rooney**



**Dr. Park**

by a panel discussion with leaders in Indiana's changing health care delivery system. The panelists are: J. Patrick Rooney, Indianapolis, chairman of Golden Rule Insurance Co.; Ben Park, M.D., Indianapolis, president of the American Health Network, Inc.; Douglas D. French, president and CEO of St. Vincent Hospital and

Health Services in Indianapolis; Steven F. Isenberg, M.D., Indianapolis, founder and CEO of Project Solo; and Gary Erskine, administrator of the Arnett Clinic in Lafayette. Each will give his perspective of developments in Indiana.

There is no fee to attend the program, which is open to all ISMA members. □



**French**



**Dr. Isenberg**

## PICI to sponsor risk management program

**P**hysicians can lower their liability and insurance costs by attending the 1995 Preferred Risk Loss Prevention Seminar, sponsored by Physicians Insurance Company of Indiana (PICI). The program is scheduled from 8:30 a.m. to 10 a.m., Saturday, Oct. 21. PICI insureds who attend will receive a 5% reduction in their premium costs. "Claims free" physicians are eligible for additional credits at renewal.

The program objectives include the following:

- Evaluate proposed managed care contracts for malpractice liability risks.
- List ways an office can minimize miscommunication with patients about coverage decisions.
- Take the necessary steps when the managed care organization does not provide coverage for the physician's recommended treatment.
- Cite documentation principles that can reduce the risk of a malpractice suit.
- Describe the roles and responsibilities of the medical review panel members.
- Course instructors are: John D. MacDougall, M.D., PICI medical consultant; Barbara A. Killila, R.N., MHA, PICI director of education, risk management; and A health law attorney from Locke Reynolds Boyd & Weisell.

CME accreditation will be 1.5 hours in Category 1 of the Physicians Recognition Award of the American Medical Association and 1.5 prescribed hours for the American Academy of Family Physicians.

The cost is \$50 in advance and \$60 at the door. □

## IMPAC luncheon to feature political commentator

**Y**ou've read his columns in *The New Republic* or seen him as a regular panelist on "The McLaughlin Group" and "Crossfire." Nationally known political commentator Fred Barnes will speak at the annual IMPAC luncheon Saturday, Oct. 21.

As senior editor and a conservative voice at *The New Republic*, Barnes writes a regular column on the presidency, known as "White House Watch." He also writes about politics and the media. His piece on health care was rated best commentary of 1994 by the *Media Guide*.

Barnes is noted for humorous and sharply worded exchanges with other panelists on "The

McLaughlin Group" and "Crossfire." He has appeared on virtually every other national television news/commentary program including: "CBS This Morning," "Nightline," "Today," "Good Morning America," "Meet the Press," "Face the Nation" and "The MacNeil-Lehrer NewsHour." On radio, he moderates the Voice of America show, "Issues in the News," and hosts a weekly radio show on the media, "What's the Story."

Barnes has written for *Reader's Digest* (for whom he is roving editor), *The New York Times*, *Newsday*, *The Wall Street Journal* and *The Los Angeles Times*, among other publications.

The cost of the lunch is \$18. □



Barnes

## Specialty groups to meet at convention

**T**hree specialty groups will meet during the annual ISMA convention at the Radisson Hotel.

### Indiana Psychiatric Society

The Indiana Psychiatric Society (IPS) Fall Symposium will cover the subject of substance abuse, with the focus on alcoholism. Topics will include diagnosis, pragmatic medical management within the constraints of the marketplace, a review of current developments in pharmacological treatment and preventing relapse.

On Friday, Oct. 20, the IPS will

hold a reception at 6 p.m., followed by a dinner and speaker from 7 p.m. to 9 p.m. The Saturday, Oct. 21, schedule includes a continental breakfast at 7:45 a.m., a general meeting at 8 a.m. and workshop presentations from 9 a.m. to 12:15 p.m. The seminar presentations will carry four hours of CME credit. Family practice CME credit will also be available. Sessions may be attended separately.

For more information and reservations, call Janice Herring at the ISMA, (317) 261-2060 or 1-800-257-4762.

### AIDME

The Association of Indiana Directors of Medical Education will hold its business meeting Friday, Oct. 20, at noon. For more information, call Dotty Martens at the ISMA.

### Indiana Roentgen Society

The semi-annual meeting of the Indiana Roentgen Society will be held Saturday, Oct. 21. The executive meeting will begin at 8 a.m., followed by the general membership meeting at 9 a.m. For more information, call Dotty Martens at the ISMA. □

## ISMA Alliance to hold 51st annual convention

**T**he ISMA Alliance will hold its 51st annual convention Oct. 19 through 21 in conjunction with the ISMA's convention at the Radisson Hotel in Indianapolis.

### Thursday, Oct. 19

- 1 p.m. .... Registration; convention convenes
- 3 p.m. .... Outgoing and incoming board of directors meeting; Sharon Scott, AMA Alliance president, speaker

### Friday, Oct. 20

- 9 a.m. .... ISMA House of Delegates opening session; ISMA Alliance president report

- 11 a.m. .... ISMA Alliance House of Delegates opening session
- 12:30 p.m. .. Luncheon honoring former ISMA Alliance presidents; Sharon Scott, AMA Alliance president, speaker
- 2:15 p.m. .... Reconvene House of Delegates business session
- 5:30 p.m. .... Social hour (lobby level)
- 6 p.m. .... Dinner honoring Ann Wrenn, AMA Alliance secretary; Clifford Kuhn, M.D., speaker
- 9 p.m. .... Afterglow reception honoring Valerie Gates, ISMA Alliance incoming president;

Western line dancing with Don and Judy Massey back by popular demand

### Saturday, Oct. 21

- 8 a.m. .... Breakfast fashion show sponsored by Parisian department store
- 10 a.m. .... House of Delegates; installation of officers
- Noon .... IMPAC luncheon
- 6 p.m. .... Presidents' Night Dinner & Dance

For information or to receive a registration form, call Rosanna Iler at the ISMA, (317) 261-2060 or 1-800-257-4762. □

## House to meet Oct. 20 and 22

**T**he ISMA House of Delegates will convene at 9 a.m., Friday, Oct. 20. Delegates selected by component county medical societies, the Resident Medical Society and specialty sections make up this legislative and policy-making body of the ISMA.

Resolutions to come before the House will be heard in reference committees scheduled between 1 p.m. and 6 p.m. Friday. The House will vote on the reference committee recommendations during its second session at 9 a.m. Sunday, Oct. 22. □

## Trade show visitors could win a trip

**N**ew products and services from more than 30 vendors will be showcased at the annual convention trade show. This one-day only exhibition is scheduled from 7 a.m. to 4 p.m. Friday, Oct. 20. Lunch will be available in the exhibit area.

Trade show visitors will have a chance to win a USAir vacation trip worth \$1,000 by asking each vendor to stamp their "passport" as they visit each booth. After a passport is fully validated by every exhibitor, visitors can deposit it in a container from which one name will be drawn as the prize winner. □

## Special hotel rates offered until Sept. 19

**T**his year's convention will be held at the Radisson Plaza & Suite Hotel, 8787 Keystone Crossing, Indianapolis.

To make reservations, call (317) 846-2700 and ask for the hotel reservation department or call 1-800-333-3333 for Radisson worldwide reservations. Indicate you are with the ISMA to receive the special convention room rates, \$90, single, or \$95, double.

The hotel reservation deadline is Sept. 19. After the cut-off date, the special room rate will be based on the availability of rooms.

The convention registration deadline is Sept. 25. □



# ISMA trustee districts





**William E. Cooper, M.D., president**  
Indiana State Medical Association  
1994-95

# Presidents of ISMA since its organization

## Medical Convention

	Elected	Served
* Livingston Dunlap, Indianapolis .....	1849	1849

## Medical Society

	Elected	Served
* William I.S. Cornett, Versailles .....	1849	1850
* Ashahel Clapp, New Albany .....	1850	1851
* George W. Mears, Indianapolis .....	1851	1852
* Jeremiah H. Brower, Lawrenceburg .....	1852	1853
* Elizur H. Deming, Lafayette .....	1853	1854
* Madison J. Bray, Evansville .....	1854	1855
* William L. Cox, Marion .....	1855	1856
* Daniel Meeker, LaPorte .....	1856	1857
* Charles F. Ford, Indianapolis .....	1857	1858
* Nathan Johnson, Cambridge City .....	1858	1859
* David Hutchinson, Mooresville .....	1859	1860
* Benjamin S. Woodworth, Fort Wayne .....	1860	1861
* Theophilus Parvin, Indianapolis .....	1861	1862
* James F. Hibberd, Richmond .....	1862	1863
* John Sloan, New Albany .....	1863	1864
* John Moffett (acting), Rushville .....	1863	1864
* Samuel L. Linton, Columbus .....	1864	1865
* Wilson Lockhart (acting), Danville .....	1864	1865
* Myron H. Harding, Lawrenceburg .....	1865	1866
* Vierling Kersey, Richmond .....	1866	1867
* John S. Hobbs, Indianapolis .....	1867	1868
* Nathaniel Field, Jeffersonville .....	1868	1869
* George Sutton, Aurora .....	1869	1870
* Robert N. Todd, Indianapolis .....	1870	1871
* Henry P. Ayres, Fort Wayne .....	1871	1872
* Joel Pennington, Milton .....	1872	1873
* Isaac Casselberry, Evansville .....	1873	1874
* Wilson Hobbs (acting), Knightstown .....	1873	1874
* Richard E. Houghton, Richmond .....	1874	1875
* John H. Helm, Peru .....	1875	1876
* Samuel S. Boyd, Dublin .....	1876	1877
* Luther D. Waterman, Indianapolis .....	1877	1878
* Louis Humphreys, South Bend .....	1878	1879
* Benjamin Newland (acting), Bedford (v.p.) .....	1878	1879
* Jacob R. West, Richmond .....	1879	1880
* Thomas B. Harvey, Indianapolis .....	1880	1881
* Marshall Sexton, Rushville .....	1881	1882
* William H. Bell, Logansport .....	1882	1883
* Samuel E. Mumford, Princeton .....	1883	1884
* James H. Woodburn, Indianapolis .....	1884	1885
* James S. Gregg, Fort Wayne .....	1885	1886
* Gen W. H. Kemper, Muncie .....	1886	1887
* Samuel H. Charlton, Seymour .....	1887	1888
* William H. Wishard, Indianapolis .....	1888	1889
* James D. Gatch, Lawrenceburg .....	1889	1890
* Gonsolvo C. Smythe, Greencastle .....	1890	1891
* Edwin Walker, Evansville .....	1891	1892
* George F. Beasley, Lafayette .....	1892	1893
* Charles A. Daugherty, South Bend .....	1893	1894
* Elihu S. Elder, Indianapolis .....	1894	1895
* Charles S. Bond (acting), Indianapolis .....	1894	1895
* Miles F. Porter, Fort Wayne .....	1895	1896
* James H. Ford, Wabash .....	1896	1897
* William N. Wishard, Indianapolis .....	1897	1898
* John C. Sexton, Rushville .....	1898	1899
* Walker Schell, Terre Haute .....	1899	1900
* George W. McCaskey, Fort Wayne .....	1900	1901
* Alembert W. Brayton, Indianapolis .....	1901	1902
* John B. Berteling, South Bend .....	1902	1903
* Jonas Stewart, Anderson .....	1903	1904
* George T. MacCoy, Columbus .....	1904	1905
* George H. Grant, Richmond .....	1905	1906
* George J. Cook, Indianapolis .....	1906	1907
* David C. Peyton, Jeffersonville .....	1907	1908
* George D. Kahlo, French Lick .....	1908	1909
* Thomas C. Kennedy, Shelbyville .....	1909	1910
* Frederick C. Heath, Indianapolis .....	1910	1911
* William F. Howat, Hammond .....	1911	1912
* A. C. Kimberlin, Indianapolis .....	1912	1913
* John P. Salb, Jasper .....	1913	1914
* Frank B. Wynn, Indianapolis .....	1914	1915
* George F. Keiper, Lafayette .....	1915	1916
* John H. Oliver, Indianapolis .....	1916	1917
* Joseph Rilus Eastman, Indianapolis .....	1917	1918
* William H. Stemm, North Vernon .....	1918	1919

* Charles H. McCully, Logansport .....	1919	1920
* David Ross, Indianapolis .....	1920	1921
* William R. Davidson, Evansville .....	1921	1922
* Charles H. Good, Huntington .....	1922	1923
* Samuel E. Earp, Indianapolis .....	1923	1924
* Eldridge M. Shanklin, Hammond .....	1924	1925

## Medical Association

	Elected	Served
* Charles N. Combs, Terre Haute .....	1925	1926
* Frank W. Gregor, Indianapolis .....	1926	1927
* George R. Daniels, Marion .....	1926	1928
* Charles E. Gillespie, Seymour .....	1927	1929
* Angus C. McDonald, Warsaw .....	1928	1930
* Alois B. Graham, Indianapolis .....	1929	1931
* Franklin S. Crockett, Lafayette .....	1930	1932
* Joseph H. Weinstein, Terre Haute .....	1931	1933
* Everett E. Padgett, Indianapolis .....	1932	1934
* Walter J. Leach, New Albany .....	1933	1935
* Roscoe L. Sensenich, South Bend .....	1934	1936
* Edmund D. Clark, Indianapolis .....	1935	1937
* Herman M. Baker, Evansville .....	1936	1938
* Edmund M. Van Buskirk, Fort Wayne .....	1937	1939
* Karl R. Ruddell, Indianapolis .....	1938	1940
* Albert M. Mitchell, Terre Haute .....	1939	1941
* Maynard A. Austin, Anderson .....	1940	1942
* Carl H. McCaskey, Indianapolis .....	1941	1943
* Jacob T. Oliphant, Farmersburg .....	1942	1944
* Nelson K. Forster, Hammond .....	1943	1945
* Jesse E. Ferrell, Fortville .....	1944	1946
* Floyd T. Romberger, Lafayette .....	1945	1947
* Cleon A. Nafe, Indianapolis .....	1946	1948
* Augustus P. Hauss, New Albany .....	1947	1949
* C. S. Black, Warren .....	1948	1950
* Alfred Ellison, South Bend .....	1949	1951
* J. William Wright, Indianapolis .....	1950	1952
* Paul D. Crimm, Evansville .....	1951	1953
* William Harry Howard, Hammond .....	1952	1954
* Walter L. Porteus, Franklin .....	1953	1955
* Walter U. Kennedy, New Castle .....	1954	1956
* Elton R. Clarke, Kokomo .....	1955	1957
* M. C. Topping, Terre Haute .....	1956	1958
* Kenneth L. Olson, South Bend .....	1957	1959
* Earl W. Mericle, Indianapolis .....	1958	1960
* Guy A. Owsley, Hartford City .....	1959	1961
* Harry R. Stimson, Gary .....	1960	1962
* Maurice E. Glock, Fort Wayne .....	1961	1963
* Donald E. Wood, Indianapolis .....	1962	1964
* Joseph M. Black, Seymour .....	1963	1965
* Kenneth O. Neumann, Lafayette .....	1964	1966
* Eugene S. Rifner, Van Buren .....	1965	1967
* G. O. Larson, LaPorte .....	1966	1968
* Patrick J. V. Corcoran, Evansville .....	1967	1969
* Lowell H. Steen, Hammond .....	1968	1970
* Malcolm O. Scamahorn, Pittsboro .....	1969	1971
* Peter R. Petrich, Attica .....	1970	1972
* James H. Gosman, Indianapolis .....	1971	1973
* Joe Dukes, Dugger .....	1972	1974
* Gilbert M. Wilhelmus, Evansville .....	1973	1975
* Vincent J. Santare, Munster .....	1974	1976
* John W. Beeler, Indianapolis .....	1975	1977
* Eli Goodman, Charlestown .....	1976	1978
* James A. Harshman, Kokomo .....	1977	1978
* Arvine G. Poppewell, Indianapolis .....	1978	1979-80
* Alvin J. Haley, Carmel .....	1979	1981
* Martin J. O'Neill, Valparaiso .....	1980	1982
* John A. Knot, Lafayette .....	1981	1983
* George T. Lukemeyer, Indianapolis .....	1982	1984
* Lawrence E. Allen, Anderson .....	1983	1985
* Paul Siebenmorgen, Terre Haute .....	1984	1986
* Shirley Thompson Khalouf, Marion .....	1985	1987
* John D. MacDougall, Beech Grove .....	1986	1988
* Fred W. Dahling, New Haven .....	1987	1989
* George H. Rawls, Indianapolis .....	1988	1990
* Michael O. Mellinger, LaGrange .....	1989	1991
* C. Dyke Egnatz, Schererville .....	1990	1992
* William H. Beeson, Indianapolis .....	1991	1993
* William C. VanNess II, Summitville .....	1992	1994
* William E. Cooper, M.D., Columbus .....	1993	1995

\* Deceased



*Editor's note: The annual reports that were not submitted in time to be included in this issue will be printed in the January 1996 issue of Indiana Medicine.*

## EXECUTIVE COMMITTEE

**William E. Cooper, M.D.,**  
president

As debates on Medicare, Medicaid and managed care continued throughout the year, the ISMA Executive Committee focused on keeping the ISMA strong and positioned to speak out on each issue.

Medicare's growing financing crisis concerns all physicians. Throughout the summer and fall, the ISMA met with members of the Indiana Congressional delegation in their districts to discuss Medicare and other pressing issues.

Goals are to minimize the level of physician and graduate medical education cuts; shift the debate from provider cuts to Medicare financing reform; passage of the patient protection act, point of service options, antitrust relief, new opportunities for physician-sponsored networks, and real regulatory relief; and to assure freedom of choice for Medicare patients.

The ISMA also conducted a health care university for Indiana congressional health and administrative staff members. The briefing included information on Medicare, Medicaid, CLIA, INCAP and the Patient Protection Act.

At the state level, Medicaid implemented the AIM system in February and with it created a backlog of millions of dollars in unpaid Medicaid claims to Indiana physicians. Through mid-year, the ISMA worked to see that members received Medicaid reimbursement,

including advances for medical services provided. The ISMA staff met weekly with the Medicaid carrier to go over specific claims and to resolve the complaints by our members about carrier down time, problems with provider numbers, cross over claims and non-payment of SOBRA claims, among others.

While on one front the ISMA advocated for Medicaid payment, on another, the Indiana General Assembly, we took a swipe at the Medicaid hassle factor. The General Assembly passed an ISMA-backed bill requiring that a 15-member committee, including a physician, must approve all rules established by the Family and Social Services Administration, which administers Medicaid. No longer will Medicaid proclaim new policies without oversight and physician input.

The ISMA Executive Committee determined at mid-year to charge consultants and non-members who attend the Medicare and Medicaid Coalition meetings that the ISMA has held for the past few years. Immediate staff who work as ISMA member employees are not charged to attend. The decision was based, in part, on the increased amount of staff time required to administer the meetings. Additionally, one-third of those in attendance were consultants who after receiving *free* information from the ISMA, *charged* ISMA members for the very same information. The ISMA's mission is to be the indispensable adjunct to the practice of medicine. We feel the policy fulfills our mission.

Managed care continued to be a concern of ISMA members. The ISMA addressed those concerns through comprehensive workshops in May, June and October.

The workshops provided information on managed care plans currently established in the state, the number of enrollees, things to look for in a managed care contract and how to determine if you will benefit from a managed care plan. Because managed care continues to be important to our members, we have devoted our convention program to the issue as well.

With ISMA membership at a record high, the Executive Committee approved phase two of the membership recruitment plan approved a year ago. The second phase created an ad hoc committee on membership and targets residents and women physicians in addition to the general membership. The campaign included focus groups of both targeted groups and direct mail appeals. The Executive Committee appointed Barney Maynard, M.D., to chair the ad hoc committee. The ISMA's strength is in its members!

April 4, 1995, marked the 20th anniversary of the passage of INCAP, the Indiana Compensation Act for Patients. In our continuing effort to protect the premier medical liability law in the country, the ISMA published a second edition of the INCAP white paper with updated statistics and information. The publication will be used as a resource for our members, legislators and media.

In another liability related issue, Physicians Insurance Company of Indiana completed its business combination with Mutual Assurance, Inc. The affiliation was through MAIC's purchase of PICI stock from the ISMA and PICOM Insurance Company. PICI remains ISMA's endorsed company with a majority of Indiana physicians serving on the company's board of directors and the claims and underwriting committees. The

## ■ annual reports

affiliation provides PICI new financial resources and new liability insurance markets with hospitals and managed care plans.

### BOARD OF TRUSTEES

**Alfred C. Cox, M.D., chairman**

It has been a year of record high membership for the ISMA. That's not surprising considering the challenges faced during the past year. Market forces' influence on health care continue to fluctuate as hospital mergers proceeded and managed care plans developed in the state. In Congress, cuts to Medicare and Medicaid are inevitable. Here in the state, Medicaid's new Advanced Information System (AIM) was anything but.

Your board of trustees' mission is to meet members' needs through service, advocacy and information. We tried to do that on many fronts this year. Many of our activities dealt with managed care. We activated the Ad Hoc Task Force on Managed Care to gather information on the most frequently used managed care plans and to develop guidelines for the review of managed care contracts. As this report is being written, data are being gathered with a report due at year's end.

In May and October, the ISMA offered "Market Reform/Managed Care Development in Indiana," a workshop that provided exclusive information about the development of managed care plans in the state. Also included was detailed information on what physicians should know before signing a contract.

At mid-year, with Congress seeking to cut \$270 billion from the Medicare budget and \$184 billion from Medicaid, ISMA board

members participated in meetings with Indiana Congressmen in every district. Our message: Medicare needs to be restructured so that both beneficiaries and providers become more cost conscious. Spending caps, continued provider payment reductions and increased taxes have been tried and have not succeeded.

Specifically, we are suggesting: 1) a threshold on out-of-pocket expense before Medigap plans kick in; 2) medical savings accounts for Medicare recipients to cover routine care while being insured for more catastrophic expenses; 3) a reduction in the dependency of future generations on Medicare through medical savings accounts so current workers can save now for health care needs in retirement; 4) that individuals with higher incomes pay a portion of the Part B premium; 5) that Medicare be simplified for beneficiaries and physicians; and 6) that private insurance options be offered along with the current Medicare plan to preserve patient choice.

We continue to take this message to our Indiana Congressional delegation and to their staffs. Their response indicates a willingness to consider options other than measures that haven't worked in the past.

Medicaid presented a particularly troublesome scenario for most of the year. Proposed cuts of between \$54 and \$184 billion (depending on whose plan you looked at) and Congressional debate about whether states should receive block grants or waivers were overshadowed in Indiana by the implementation of the AIM system. With Medicaid falling more than \$100 million behind in payments to physicians, the ISMA sought and received advances for members. Weekly

meetings with the carrier to review specific problems proved fruitful in a number of cases.

Many ISMA members had questions about the Medicaid Primary Care Case Management System and the Risk-Based Managed Care program. At mid-year, the ISMA began compiling information and conducting interviews with ISMA members who are participating in each program. The information will be provided through *Indiana Medicine* to doctors in counties that are scheduled to begin the programs this year.

This year marked the affiliation of Physicians Insurance Company of Indiana (PICI) with Mutual Assurance, Inc., (MAIC), one of the strongest and most successful medical professional liability insurers in the nation. The affiliation provides PICI with increased financial resources, an A+ rating from A. M. Best and a larger market including hospitals and managed care plans. PICI's contracts and commitments to policyholders remain unchanged. The ISMA's guiding involvement with PICI continues through a long-term endorsement agreement. The board views the affiliation as a win-win situation for both the ISMA and PICI.

In terms of the future, the ISMA is preparing on several fronts. The ISMA intends to go online in the near future to provide members access to the ISMA, the Internet and World Wide Web. The Net offers tremendous potential for the ISMA to service members' needs. Specific services include E-mail, the ability to register for ISMA programs via computer, access to ISMA publications and timely information about legislation or other issues.

At the national level, the



Federation has begun a study to look at the future needs and concerns of physicians and how organized medicine can continue to meet them. The study will make recommendations that redefine relationships in organized medicine in order to: 1) enable the medical profession to speak with one voice on critical issues; 2) create more effective ways to accomplish work on behalf of the medical profession; 3) eliminate or minimize duplication of services between medical societies; and 4) focus each element of organized medicine on what it does best.

Since research began, four major areas of consensus have emerged: 1) physicians will need greater public trust and credibility and an improved image as patient advocates; 2) physicians must be involved in defining quality care, practice parameters and standards of care; 3) physicians will need effective representation which is focused on the future, not on protecting the past; and 4) physicians need better preparation for the changing practice environment.

The consortium and project team responsible for the study are discussing specific changes in structure and governance of the federation, the basis of representation, roles and responsibilities of components of the new Federation and collaborative efforts.

Four Indiana physicians serve on the consortium: Michael Mellinger, M.D.; William Beeson, M.D.; Shirley Khalouf, M.D.; and Marvin Priddy, M.D.

The ISMA Board of Trustees is interested in your comments and concerns on this or other topics.

The ISMA has had a great year thanks to the input of very capable trustees and leadership. The success of our organization is also

due in no small part to the work of the ISMA support staff. Special thanks to Rick King, executive director, Susan Grant, Mike Abrams, Adele Lash and Jenny Floyd for a tremendous job.

## AMA DELEGATION

**John D. MacDougall, M.D.,**  
chairman

I would like to thank the members of our delegation for their dedication and effort in maintaining Indiana's active role at the AMA House of Delegate meetings:

### Delegates

John Knote, M.D., Lafayette  
Mike Mellinger, M.D., LaGrange  
William Beeson, M.D.,  
Indianapolis  
John MacDougall, M.D.,  
Indianapolis  
Shirley Khalouf, M.D., Marion

### Alternates

Alfred Cox, M.D., South Bend  
Max Hoffman, M.D., Covington  
Paula Hall, M.D., Indianapolis  
George Rawls, M.D., Indianapolis  
Barney Maynard, M.D., Evansville

The delegation unanimously voted at the 1994 ISMA Annual Convention to place in nomination the name of John A. Knote, M.D., for AMA vice speaker. I am pleased and proud to announce that with the diligent efforts of John and the entire Indiana AMA delegation on June 20, 1995, the AMA House of Delegates elected John A. Knote, M.D., as their vice speaker. I want personally to thank all ISMA members who played a role in this successful and rewarding endeavor. John will work tirelessly as AMA vice speaker and proudly represent the physicians of Indiana.

## Interim meeting

The AMA House of Delegates met Dec. 4-7, 1994, in Honolulu with 413 delegates representing state medical associations, national medical specialty societies, specialty sections and government services.

The delegates considered 92 reports and 190 resolutions. The board submitted a report that described current trends in managed care, summarized risks and opportunities for physicians and patients and presented a detailed AMA strategy for managed care and the private sector. The House approved the report and emphasized the following four principles:

1. Professionalism - medical science and ethics;
2. Patient and physician autonomy;
3. Patient and physician rights; and
4. Practical assistance to physicians.

At the direction of the ISMA House of Delegates, the Indiana delegation introduced three resolutions: 218, 219 and 607. Resolution 218 dealing with the AMA's position on gun control was considered at the 1994 interim meeting, and the AMA House of Delegates rejected the first resolve and added a portion of the second resolve: "support scientific research and objective discussion aimed at identifying causes of and solutions to the crime and violence problem" to AMA Policy 145.986. Resolution 219, which dealt with including gram stain in a physician's armamentarium, was adopted. Resolution 607 concerning AMA fiscal note accountability was also considered, and the first resolve was adopted but the second resolve was rejected.



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### Annual meeting

The 1995 AMA Annual Meeting, June 18-22, Chicago, was held with 432 voting delegates considering 87 reports and 233 resolutions. The House considered many diverse issues in socio-economics, science, medical education and public health. Newt Gingrich, speaker of the U.S. House of Representatives, spoke to the House of Delegates via a live satellite hookup, and answered questions on Medicare reform.

An additional resolution was introduced from our ISMA House of Delegates relating to tougher licensing laws for the sale of tobacco. Resolution 401 was considered and the following substitute resolution was adopted:

"RESOLVED, That our American Medical Association seek and support legislation that would restrict the display of tobacco products and would permit sales of tobacco only with the assistance of a sales person; and be it further

RESOLVED, That our AMA work with the federation to seek implementation of laws based on existing model state legislation 'To Prohibit the Sale to or Purchase of Tobacco Products by Individuals Under 21 Years of Age'; and be it further

RESOLVED, That our AMA encourage strict enforcement of existing laws to restrict access to tobacco products by individuals under the age of 21; and be it further

RESOLVED, That Policies 505.973, calling for bans on vending machines for tobacco products, and 505.990, calling for model legislation to restrict children's access to tobacco, be reaffirmed."

The House elected Daniel Johnson Jr., M.D., president-elect, and Richard Corlin Jr., M.D., as speaker of the house.

The entire delegation works diligently at each AMA meeting to voice the "Indiana perspective" on vital issues affecting the Hoosier physician and the delivery of health care in the state. If you can't attend the meetings, you can still be assured that you are represented through your delegation. Let us know your opinions!

### TREASURER

**Timothy N. Brown, M.D.**

An unaudited report of the revenues, expenditures and balance sheet of the ISMA as of Aug. 31, 1995, is available during the sessions of the House of Delegates and is referred to Reference Committee 1.

The ISMA has reached its strategic plan goal to have 18 months of operations reserve in cash and cash equivalents. As of June 30, 1995, 28 months of operations expenditures are in cash and cash equivalents.

### RESIDENT PHYSICIAN SECTION

**Gregory C. Risk, M.D., trustee**

The ISMA Resident Section had an active and productive year due to the support of the ISMA membership and staff. Efforts have primarily focused on resident membership and increased participation at the state and national levels.

Members of the resident section hope it becomes an arena where residents can be introduced to the role of organized medicine, and future leaders will develop. To encourage this goal, a special resident membership package was created with the assistance of the ISMA staff, which has proven successful. Presentations by the

resident section officers and ISMA staff at some residency training centers have generated considerable interest.

Several members have participated by representing the resident section at ISMA committee and board meetings. We believe that resident input, especially in areas of undergraduate medical education and residency training, is beneficial to the committees and the future of medical training in Indiana.

At the national level, our section has sent a delegation to the AMA annual meeting in Chicago and the interim meeting held this December in Hawaii. During the last year, we hosted the Great Lakes coalition meeting and have participated in the state leadership sessions held at each AMA meeting. Additionally, Glenn Loomis, M.D., chief resident at Community Hospital, was nationally recognized for his leadership by winning an AMA /Glaxo award and attending the National Leadership Conference in Washington, D.C. Ruchir Sehra, M.D., was the AMA-RPS representative to the National Board of Medical Examiners. Several other active members serve on national specialty society committees or in leadership positions.

I would like to express our appreciation to the Indiana State Medical Association. The support of the membership and the assistance of the staff have been fundamental in our growth to this point, and we look forward to continued success in the years to come.

## MEDICAL STUDENT SECTION

**Erin Baker**, president-elect

The MSS has had a very active and fulfilling year.

Thanks to aggressive recruitment at the regional campuses and in Indianapolis, recruitment was at its highest ever! Membership drives at freshman orientation's "Nite at the Zoo" and personal recruiting events at the center sites (which included pizza parties and cookouts) allowed large numbers of incoming and veteran medical students to ask questions and receive information about the ISMA and AMA. On behalf of the MSS officers, I wish to thank all those who participated in this year's recruiting effort.

The MSS also was active on state and national levels with increasing member interest in convention attendance and convention positions. Thanks to ISMA support and a student member copay system, the MSS sent students to the annual and interim AMA national conventions, the AMA sectional meeting in Dayton, Ohio, the AMA National Leadership Conference in Washington, D.C., and the ISMA leadership conference in Indianapolis.

The ISMA-MSS worked to improve its position on a national level by increasing member involvement on convention committees and on year-long standing committees. I am pleased to announce that we placed two second-year students on convention committees at I-94 (S. Lindsay on parliamentary procedures and E. Baker on rules) as well as one student on a committee at I-95 (E. Baker as testimony coordinator). The ISMA-MSS is also pleased to announce the appointment of J. Oester (past president) to the position of section coordinator for

the 1995-96 term.

Our presence nationally was also displayed through two separate resolutions submitted at I-95, both of which received tremendous support: "Alcohol Impairment During Medical School" (A. Stevens and M. Eversoll) and "Incorporation of Domestic Violence Education as Part of Medical School Curriculum" (D. Nguyen).

Thanks to the momentum and interest gained in our state society during the past year, the ISMA-MSS hopes to continue its efforts on state and national levels. Goals for next year include continuing to increase membership, increasing involvement of the Indianapolis campus students, increasing leadership on a state and national level and strengthening our ties to the physician section and the residents section.

The members of the MSS wish to thank the ISMA for its continued support.

## PHYSICIANS INSURANCE COMPANY OF INDIANA

**M. David Duncan**, PICI president and CEO

The year 1995 will be recorded as a hallmark year for PICI. We have taken actions to assure the ongoing financial strength of the company, as well as its ability to serve Indiana physicians and their colleagues into the 21st century.

Foremost among these actions was the affiliation of PICI with MAIC Holdings, Inc., a multistate health care insuring organization. MAIC is composed of insurers that are leaders in their respective operating areas. Together, under the MAIC umbrella, these companies have assets of more than \$671 million, surplus in excess of \$172

million and claims reserves of more than \$403 million.

An immediate benefit of this affiliation was a rating of "A+" (superior) from A.M. Best Company, the recognized authority on fiscal positions of insurers. Current and future policyholders will have the peace of mind that comes from the highest level of insurance security.

Although the inherent professional liability insurance needs of physicians remain unchanged, trends and developments in health care are creating new challenges. Traditional concepts of health care delivery are being altered by socioeconomic pressures, new health care organizational structures and the developments of new relationships. Long-term, the benefits of PICI's affiliation will relate to these complex professional liability issues.

Specifically, PICI now has the capacity as well as the ability to provide products and services for the full spectrum of the Indiana health care community. This includes hospitals and other provider institutions, managed care plans and other integrated health services entities and all licensed health care professionals. Very importantly, this product and service capability will extend to the needs of Indiana organizations and individuals with risk exposure in other states.

Indiana physicians will continue to need services that respond to the special characteristics of the Indiana medical malpractice environment. It always will be essential that they have a direct voice in the conduct of their insurer's operations, especially with respect to underwriting, claims and risk management services. PICI, of course, is dedicated to those operating philoso-



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phies and objectives.

As PICI continues to grow, we will follow the principal guidelines that have brought us nearly 14 years of success and market leadership: quality coverage, aggressive claims defense and value-added services. In Indiana, as well as in many other states, there is growing evidence of predatory pricing in professional liability insurance. Some insurers appear to be staking their financial futures on the possibility that federal tort reforms will reduce claim frequency and/or severity. Others are intent on gaining market share by offering coverage to larger health care entities at huge discounts. In reality, the professional liability insurance industry potentially faces a period of increasing volatility. The spread of managed care and the formation of large, faceless health provider entities could increase claims. Any federal tort reform will be tested in the judicial system.

Underpricing in the Indiana marketplace is particularly dangerous because of the resultant underfunding of the Patient Compensation Fund. By providing pricing bargains to a few, predatory insurers only raise the possibility of an increase in the PCF surcharge for all Indiana health care practitioners. PICI and the ISMA, as in the past, will aggressively oppose irresponsible pricing tactics by insurers seeking short-term gains.

The board of directors, management and staff of PICI look forward to the remainder of 1995 and 1996 with great enthusiasm. The protection needs of Indiana physicians and their colleagues are changing, and it is essential that PICI keeps pace. Our operating philosophies and objectives are the same, but we are better prepared

than ever to assure they are accomplished. PICI and the ISMA, working together, will continue to "Make the Difference" in professional liability protection for ISMA members.

### FIRST DISTRICT

**Barney R. Maynard, M.D.**, trustee

The annual meeting of the First District was held in May. The guest speaker for this year's meeting was Rep. Vaneta Becker, who is from the First District area and has come to prominence in the state legislature regarding health care issues. Rep. Becker, with her assignment as chair of the House Public Health Committee, is a key legislator for many ISMA legislative initiatives. Her appearance as speaker to First District physicians and spouses was much appreciated and also gave First District physicians the opportunity to thank her for her efforts in health care legislation.

On a membership matter, the board of the Vanderburgh County Medical Society voted to exempt residents from local dues to the county medical society. VCMS staff met with residents at both Deaconess and St. Mary's hospitals to discuss the benefits of membership in organized medicine at all levels. Hopefully, this will encourage a greater participation in organized medicine by resident physicians in the First District.

The Vanderburgh County Medical Society has been engaged this past year with the Tri-State Business Health Care Coalition regarding the public release of "physician specific" outcome data. The VCMS opposed the release of information based on the Medisgroup data base because of the known flaws within that

system. As a result, the business coalition has not only delayed the projected date for release of this information but has backed off the use of the Medisgroup data base and is supporting the data collection of the Indiana Hospital Association. The Vanderburgh County Medical Society will continue its efforts to work with the business coalition but will recognize and uphold its role as an advocate for its member physicians.

Many First District physicians and spouses continue to be involved in the legislative process. Many have taken the time to contact our local legislators. Many have also become involved in the fund raising of local office holders. This recognition by the medical family of the need for activism for our patients and profession will be in increasing demand in the coming months and years.

Finally, the physicians of the First District would like to join all ISMA members in congratulating John Knoté, M.D., on his election to vice speaker of the AMA House of Delegates. Dr. Knoté's steadfast faith in organized medicine and his years of commitment to the work of medicine have paid rich dividends. His election is a source of pride for all Indiana physicians.

### THIRD DISTRICT

**John H. Seward, M.D.**, trustee

Throughout this year the officers of the Third District met on two times to discuss the planning of the annual meeting, resolutions and legislations. The annual meeting was held May 17 at Fuzzy Zoeller's Covered Bridge Golf Course in Sellersburg, Ind. Before a rather large turnout, the annual meeting was conducted by Daniel



Cannon, M.D., president and alternate trustee of the Third District.

During the meeting, the 1994 minutes were read and approved. Robert Arnold, M.D., of Washington County was elected the new president for the Third District, and Kalen Carthy-Kemker, M.D., of Washington County was elected secretary. Kevin Burke, M.D., of Clark County was elected president-elect as well as the new alternate trustee for the next three years.

After the business meeting John R. Hale, Ph.D., an archeology professor at the University of Louisville, spoke on "Medicine Man & Medicine Woman: Native American Tradition in Healing." His talk was enjoyed by all.

The next meeting will be hosted by the Washington and Scott County Medical Society on May 15, 1996, in Salem.

If there are any questions, please call me at (812) 279-3595.

## FOURTH DISTRICT

**Arthur C. Jay, M.D., trustee**

The Fourth District quarterly meetings were well-attended. Discussions continued to center on the lack of Medicaid reimbursement, the increase in managed care programs with increased competition from HMOs and other health reform issues. The shortage of physicians in some areas, particularly southeastern Indiana, was discussed, and the question of a branch of Indiana University School of Medicine in southeastern Indiana and Hanover was raised. Questions have been sent to the dean of the medical school as well as Gov. Evan Bayh concerning the feasibility of a medical school branch.

The Fourth District wishes to express its support of William Cooper, M.D., ISMA president, and his candidacy for election as an AMA alternate delegate.

Leon Michl, M.D., was elected district president; Howard Jackson, M.D., secretary-treasurer; and Dan Walters, M.D., president-elect.

The annual meeting was held at the Dearborn County Club. The officers updated members of the medical society and gave an excellent presentation.

We sincerely appreciate the help and information from Dr. Cooper; Richard King, ISMA executive director; and Janna Kosinski, ISMA field staff representative. We look forward to the meeting in Jefferson County next year.

## SIXTH DISTRICT

**Ray Haas, M.D., trustee**

As the year winds down to the time of the ISMA Annual Meeting, the members of the Sixth District look back on a year dominated by the managed care situation. Concerns and questions are posed by physicians as how to best be the patient's advocate, providing the best care possible while at the same time maintaining a satisfactory income to provide for family needs. With ever increasing pressures from both insurance companies and government to decrease medical costs, it becomes increasingly more difficult to provide the same level of medical care without changes in the style of practice. This has led to the formation of multiple PHOs and to the buyout of many practices by hospitals or specialty groups seeking to maintain their referral base and provide physician availability for patients enrolled in

hospital-based insurance plans.

The Sixth District Annual Meeting was held in Shelbyville, Ind., with golf at the Elks Club and a dinner and meeting at the Holiday Inn. The late spring rains didn't seem to dampen the golfers' enthusiasm. Either the rain or, more likely, general apathy contributed to only a moderate turnout of members. This has continued to be a problem, so the Sixth District has decided to try to start alternating the meeting site only between New Castle and Richmond. Also during the business meeting, Howard Deitch, M.D., was elected alternate trustee.

The program speaker presented an interesting discussion on physician-controlled managed care in the South Bend area. Brief reports were given by various ISMA officers. This was certainly appreciated and worthwhile. It is unfortunate that more of the Sixth District members could not attend.

On behalf of the membership, I wish to thank Bob Sullivan, ISMA field staff representative, and the entire ISMA staff for their support and assistance throughout the year.

## SEVENTH DISTRICT

**John M. Records, M.D.; Bernard J. Emkes, M.D.; and Paula A. Hall, M.D., trustees**

We are pleased to report that Seventh District Medical Society membership continues to steadily increase.

We are very appreciative of those members of the Seventh District who gave their time to serve as Doctor of the Day during this year's legislative session. As in previous years, the Seventh District continues to be well represented during individual and

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organization-sponsored trips to Washington, D.C., as our officers visit with elected officials on Capitol Hill.

On June 28, Craig A. Moorman, M.D., Seventh District president, presided over a record number of attendees during the Seventh District Medical Society's Annual Meeting at the Indianapolis Zoo. Members, their families and guests were entertained during dinner by Peggy Melchior's Marionettes, and afterwards by a performance of the zoo's popular dolphins.

ISMA President William E. Cooper, M.D., thanked the members for supporting their county and district medical societies and encouraged the physicians to remain and/or become active in their organizations. Dr. Cooper also shared the good news regarding the election of John Knoté, M.D., as vice speaker of the AMA House of Delegates.

We appreciate the representation the Seventh District enjoys by Peter L. Winters, M.D., as speaker of the ISMA House of Delegates; John D. MacDougall, M.D., and William H. Beeson, M.D., as AMA delegates; and George H. Rawls, M.D., and Paula A. Hall, M.D., as AMA alternate delegates.

We remind the Seventh District members that the district maintains a hospitality suite for their convenience during the annual convention and encourage them to stop by to relax, store their personal belongings or take advantage of a good location for an impromptu meeting.

Here are the results of this year's Seventh District elections:

Robert D. Glassman, M.D., of Hendricks County - president-elect;

John F. Schneider, M.D., of Marion County - secretary-treasurer;

Paula A. Hall, M.D., of Marion County - trustee;

Frank Johnson, M.D., of Marion County - alternate trustee; and

Craig A. Moorman, M.D., of Johnson County - alternate trustee.

We acknowledge and appreciate the leadership and representation provided during the past three years by Ronald K. Stegemoller, M.D., a past president and Seventh District trustee, of Hendricks County. Dr. Stegemoller chose not to stand for re-election due to increasing demands on his time. We thank Dr. Stegemoller for the time he gave on behalf of Seventh District members and encourage him to resume his district activities in the future, when time permits.

Russell L. Judd, M.D., a urologist from Marion County, assumed his office of Seventh District president following the annual meeting. Because he most recently served as president of the Indianapolis Medical Society, we know that Dr. Judd will do a superb job as president of the Seventh District.

Congratulations to all of the newly elected and re-elected officers of the Seventh District!

### **EIGHTH DISTRICT**

**John V. Osborne, M.D., trustee**

The Eighth District Medical Society held its annual meeting June 7, 1995, at the Portland Country Club. The Jay County Medical Society was host and Kathleen Galbraith, M.D., conducted the meeting.

U.S. Rep. David McIntosh had hoped to attend the meeting as our speaker, but since he was unable to leave Washington, D.C., we

conducted a half-hour telephone conference with him discussing numerous current social, medical and political problems.

The Eighth District election of officers was held, and it was decided that the upcoming officers of the Madison County Medical Society would serve as president and secretary of the district society. The next annual meeting was scheduled for June 5, 1996, at the Anderson Country Club.

A golf outing preceded the dinner and meeting and was thoroughly enjoyed by all.

### **NINTH DISTRICT**

**Stephen D. Tharp, M.D., trustee**

Once again, the Ninth District has demonstrated its commitment to leadership and service for both medicine and Indiana. Two of our district members will no doubt be instrumental in developing policy at the state and national levels. This past year has marked the return to the Statehouse of a physician as an elected representative of Indiana. Timothy Brown, M.D., was successful in his bid to obtain a seat as state representative and has become a leader among the voices preparing our state for the 21st century. His insight and judgment have proven to be quite valuable to Indiana for both medical and non-medical issues.

We also are proud to be the home district for John Knoté, M.D., who captured the office of vice speaker of the AMA House of Delegates in a landslide victory. Dr. Knoté has left no doubt that there is more than corn in Indiana! We look forward to supporting him in his endeavors at the AMA level and wish him luck in his new office.

The Ninth District annual



meeting was held June 14, 1995, at the Ulen Country Club in Lebanon, Ind. The Boone County Medical Society, host for this meeting, did a superb job. I am pleased to report that Gerald Wehr, M.D., of West Lafayette was elected alternate trustee. I look forward to working with him in the coming years. It was a productive year for the Ninth District and I look forward to continued service in organized medicine.

## ELEVENTH DISTRICT

**Regino B. Urgena, M.D., trustee**

Shirley Khalouf, M.D., was elected to the AMA Bylaws Committee during the June 1994 meeting of the House of Delegates. Our district is proud of her many accomplishments as an Indiana delegate to the AMA.

Throughout 1994, many physicians from the Eleventh District participated in the campaign for our issues in the state legislature and in the U.S. Congress with letters and telephone calls. During the debate on health care reform, our physicians attended legislative forums and town hall meetings. Drs. Keith Rockey and Reg Urgena, members of the ISMA speakers bureau on health care reform, addressed several groups in the district. In September, when the health care reform bills came out of the different committees in the U.S. Congress, Congressman Buyer conducted a teleconference with physicians in Marion to update them about the provisions and status of the different bills. There was an extensive discussion; physicians had many of their questions answered before Congressman Buyer was called back to the House chamber for a vote.

The annual meeting was held Sept. 14, 1994, at the Honeywell Center in Wabash, Ind. It was well-attended and managed by District 11 President Bill Dannacher, M.D.; Rick Ryan, ISMA field staff representative; Alliance member Lynn Dannacher; and members of the Wabash County Medical Society. Tim Brown, M.D., ISMA treasurer and then candidate for District 41 representative, was the guest speaker. In keeping with a practice that was started three years ago, all the candidates for the state legislature from our six-county area were invited to the dinner program. The physicians and their spouses were able to meet and discuss issues of mutual concern with the candidates in a relaxed and convivial atmosphere.

The 1995 annual meeting will be held Sept. 13 at Grissom Air Force Base. There will be a golf tournament, and Agnes Kenny, M.D., and the Miami County Medical Society members are preparing an interesting program for the dinner.

## TWELFTH DISTRICT

**Joseph R. Manthey, M.D., trustee**

The Twelfth District held its annual meeting Sept. 14, 1995, at Sycamore Hills Country Club in Fort Wayne. The meeting was preceded by golf on the Jack Nicklaus-designed course.

I wish to formally welcome Scott Wagner, M.D., as the Twelfth District alternate trustee. David Haines, M.D., is the current vice president of the Twelfth District and has been nominated to serve as president in 1995-1996. Kosciusko County will host the 1996 Twelfth District meeting at the Stonehenge Golf Club.

Our district Alliance remains

very politically active and hosted another successful legislative forum last fall, which was remarkably well-attended by area legislators. Members of the Twelfth District Medical Society and Alliance also were well-represented at the Statehouse on Medicine Day, Jan. 25.

I encourage everyone to remain informed and active in organized medicine. I look forward to serving again as your trustee and remain available for any questions or concerns.

## COMMISSION ON CONSTITUTION & BYLAWS

**Fred W. Dahling, M.D., chairman**

The Commission on Constitution & Bylaws did not meet formally this year. Bylaws changes, mandated by the passage of Resolutions 94-7, 94-11 and 94-45 during the 1994 ISMA annual convention, were incorporated into the ISMA bylaws by Ron Dyer, ISMA general counsel, and his staff. The bylaws were approved by the members of the commission by mail ballot.

The updated version of the 1994 ISMA Constitution & Bylaws, as distributed to the House of Delegates, will serve as the formal report from the commission.

I wish to officially thank the members of the commission for their help and critique in carrying out the duties of the commission.



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### COMMISSION ON LEGISLATION

**Barney R. Maynard, M.D.,**  
chairman

As chairman of the commission on legislation, it is my pleasure to submit this report on the ISMA legislative activity for 1995. With the stunning results of the 1994 general election, the Statehouse saw new leadership in the House of Representatives. This legislative session was marked by a great deal of controversy, with two massive demonstrations by organized labor and a walk-out of House Democrats that jeopardized every piece of legislation. But through it all, I am pleased to report to the membership what I believe to have been a very successful session.

At the October 1994 annual meeting of the ISMA House of Delegates, the commission was given 22 legislative initiatives. While all initiatives were filed, the commission felt that priorities had to be set. As in every organization, there are limits on resources to handle a given legislative package. And with the change in the House make-up, it was very clear that the new Republican legislature was looking for "less government," not more. With that in mind, the commission set a priority list of issues. Of the list, I can report success on all but one of the items.

Our successful initiatives included the following:

Senate Bill 90 made a simple but very large change in the Indiana Good Samaritan statute. Prior to passage of S.B. 90, the statute applied to help given at the scene of an "accident" only; the new statute applies to accidents and any "medical emergency."

Senate Bill 76 is a new law that allows governmental units to purchase malpractice insurance to

cover a free clinic. The insurance would then cover any health care professional (including physicians) rendering free care while working at the clinic.

House Bill 1623 requires that the attorney general attempt to contact a physician before a hearing by the Indiana Medical Licensing Board on summary suspension of that physician's license. It also requires that the physician be allowed to make a statement at the hearing.

House Bill 1383 adds HMOs to the so-called "corporate practice of medicine" statute. Under Indiana law, a corporation may hire a physician, but only the physician can make medical decisions. Prior to this law, HMOs were not included under this provision.

Perhaps the two most significant "wins" dealt with health system reform and Medicaid. Senate Bill 576 (and its companion House Bill 1009) passed and provide some incremental health system reforms. This bill expands small group health insurance reforms from business of three to 25 to business of three to 50. It establishes Indiana's first limit on pre-existing disease exclusions, limiting this to nine months. The bill provides that once having served a waiting period for a pre-existing condition, one does not have to serve it again as long as insurance is continuously maintained. There are portability features in the statute. And it changes state law to treat medical savings accounts (MSAs) favorably at such time as the federal government allows favorable tax treatment of such accounts that will make MSAs a reality. The commission was very pleased with the passage of the law. However, it is important to remember that because of ERISA, these reforms

will apply to only 40% of Hoosiers who obtain their health insurance through their employer. The other 60% are employed by companies with ERISA-protected health plans. Finally, this legislation passed despite the most forceful lobbying opposition by the Indiana Chamber of Commerce and the Indiana Manufacturers Association. Physicians owe much gratitude to Sen. Pat Miller, who introduced S.B. 576, and Rep. Vaneta Becker, who introduced H.B. 1009.

Virtually every physician in Indiana is aware of the current Medicaid problems. House Bill 1758, again introduced by Rep. Becker, will hopefully bring some accountability to the program. The bill requires that any change in Medicaid policy must have a 45-day waiting period after notice of the change has been made public. The bill requires that clinical panels be set up to advise on any change in medical policy. And, most importantly, this bill will place a 15-member citizen board over the Family and Social Services Administration, of which Medicaid is a part. Heretofore, the head of Medicaid was accountable only to the governor. Now, all policy changes must be reviewed by this citizen panel. The law requires that at least one panel member be a physician. This bill will not fix Medicaid; however, it will bring some much needed public accountability to the program.

Those were the successes of the ISMA in this year's legislative session. Our only priority initiative loss was a state-based Patient Protection Act (PPA). This bill was strenuously opposed by the Indiana Chamber of Commerce, the Indiana Manufacturers Association and the insurance industry. I regret to report that we were

unsuccessful in moving this bill. However, in another initiative introduced by the Indiana Hospital Association (IHA), a piece of the PPA was passed into law. The IHA bill would require some form of "due process" be accorded hospitals deselected from managed care networks. Our legislative staff was able to have the language changed to include physicians in the due process requirement.

As always, ancillary health care providers were seeking to expand their scope of practice into the area of physicians. Physical therapists attempted to gain direct access to back pain patients and were soundly turned away. A much more intense effort was made by pharmacists. The pharmacists attempted to open their scope of practice to alter medication, even stop a medication, order diagnostic testing and "manage patient drug therapy" in a variety of clinical settings including hospitals, nursing homes, community mental health centers, group homes and HMOs. As is always the case, the pharmacists would hide behind the liability skirts of physician-written protocols. All of this language was stripped from the bill. While this initiative did not become law, I would take this opportunity to warn the membership that pharmacists, like many other groups, have a very aggressive and ambitious legislative agenda to dramatically expand their scope of practice. They will be back year after year. It will take the active participation of the membership to keep patient care where it belongs, squarely in the hands of physicians.

This is the 20th year of the Indiana Compensation Act for Patients (INCAP). As usual, an attempt was made to open the act to amendment. This was at-

tempted under the guise of fixing a legitimate problem in how malpractice actions resulting in a judgment for the plaintiff are handled by the attorney general's office and the Indiana Medical Licensing Board. Our legislative staff was able to find a way of fixing this problem with insertion in language in the above mentioned H.B. 1623. This kept the malpractice statute just exactly where we want it, closed and not available for amendment!

Your ISMA Commission on Legislation feels that we have had a successful 1995 and hope the membership agrees. A very large thank you must go to our legislative staff of Mike Abrams, Lou Belch and Katherine Vaughn. Also, a heartfelt thanks to every physician and physician spouse who took time to learn about the issues and to contact their state legislators. Grassroots effort is a real cliché. But it is indeed absolutely essential if legislative initiatives are to be successful. The ISMA Commission on Legislation urges every member to get involved in the legislative process. We can, and have, made a difference. The "House of Medicine" is sailing in very dangerous waters. And while it may be distasteful to many physicians, if we do not involve ourselves in the political process, the seas will only get rougher.

The Commission looks forward to serving the membership in 1996.

### COMMISSION ON MEDICAL EDUCATION

**Glenn J. Bingle, M.D., chairman**

There have been two meetings of the commission since the last report. We are deeply indebted to the members who volunteer their

time to site survey the 62 hospitals and organizations accredited by the ISMA to provide continuing medical education.

Seventeen hospitals and two professional organizations have received reaccreditation and continue to pursue excellence in presenting statewide education to physicians. Most of these were reaccredited for a four-year term.

We successfully sponsored Resolution 94-5, Financial Compensation to Primary Care Physicians Who Provide Training for Physicians in Training. This resolution and other efforts help provide additional financial support from the Indiana legislature for family practice training opportunities in Indiana.

The Committee for Review and Recognition voted to accept and file the commission's interim report, thus continuing to recognize the ISMA and its Subcommittee on Accreditation and their work. I was a guest of the Accreditation Council for Continuing Medical Education on July 13 and 14 and learned of its efforts to reform the process of accreditation following hundreds of comments from providers, including state medical associations.

We have adopted a formal process for handling complaints regarding accredited sponsors/providers. We have had excellent compliance with the newly enacted Guidelines for Commercial Support for Continuing Medical Education based on the annual reports we receive from sponsors.

We had the opportunity of attending the Second Conference on Personal Physician Education in Chicago and remain confident that Indiana's needs are being met by the states of Colorado, Wisconsin, Maryland and California - all of which have well-recognized and



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funded programs in this area.

We enjoyed the opportunity to meet with the World Health Organization's delegation of physicians from the Republic of China who want to learn about our CME accreditation process.

Current investigation into reorganizing the commission and subcommissions into a single entity is proceeding. Further details on proposed changes in the entire CME accreditation process are needed before presenting a formal resolution to the board. This should be available in the next six months. Our current structure mirrors the ACCME.

Special thanks to Dotty Martens who handles the myriad of paperwork that accreditation processes require.

## **COMMISSION ON PHYSICIAN ASSISTANCE**

**Robert Nelson, M.D.**, chairman

1995 has been a busy year for the ISMA Commission on Physician Assistance. The number of referrals continues to rise at a steady pace. As of the second quarter of 1995, we have 86 active cases. Approximately 75% of these cases involve the diagnosis of chemical dependency, with the remaining 25% having a primary psychiatric diagnosis. We have noted an increase in the number of calls regarding what we term the "disruptive" physician. Protocols have been developed and assistance given to these callers.

As a result of our work with the Indiana Hospital Association, we have a steady increase in the number of physician referrals from hospital administration. These referrals have been very appropriate and assistance given to the physician with the support of the

hospital administrators.

The pamphlet designed by our staff last year outlining the services of the ISMA Physician Assistance Program (PAP) is an invaluable guide for physicians and hospitals and is getting a lot of circulation. If you would like this pamphlet, please contact Candace Backer at the ISMA.

Our work as a commission this year has focused on mechanisms to fund the Physician Assistance Program. In July we implemented an administrative fee for all participants. There will be a \$50 per month fee for ISMA members, and \$100 per month for non-members. For those physicians facing financial hardship, assistance will be available. This fee will assist in covering the administrative costs of the program. We will continue to examine ways in which to fund our program.

The commission has requested and received approval to implement a computer software program for the PAP. This will enable us to more easily track program participant progress, trends, drugs of choice, relapse rates, etc. We are excited by this and hope to have it operating by October.

## **COMMISSION ON SPORTS MEDICINE**

**Robert Wylie, M.D.**, chairman

The ISMA Commission on Sports Medicine is pleased to continue to improve the medical care of Indiana athletes. The commission accomplished revising the IHSAA sports medical form and disseminating the form to Indiana high schools. The form includes a medical questionnaire and a more comprehensive physical form. Although every member of the commission gave their input on

this project, the subcommittee deserves recognition for its hard work as well. The subcommittee includes: Tom Sevier, M.D.; John Welch, M.D.; Ray Ryan, M.D.; and Robert Wylie, M.D.

The commission continues to update and disseminate the sports nutrition packet to Indiana schools, promote the guidelines on concussions developed by the commission, and work with the Indiana State Department of Health, Division of Oral Health, and the Injury Resource Center.

As chairman, I would like to thank those commission members who continue to bring forth issues for the commission to research and implement a plan of action that will benefit Indiana athletes and personnel.

## **GRIEVANCE COMMITTEE**

**Richard B. Schnute, M.D.**, chairman

The Grievance Committee, including Max Hoffman, M.D.; Freeman Martin, M.D.; John Pless, M.D.; Susan Pyle, M.D.; and John Seward, M.D., investigated multiple complaints during the 1994-95 period and worked diligently to fairly resolve these issues.

Complaints included differences of opinion concerning diagnosis and treatment, fees and charges and accusations of improper deportment. Most misunderstandings resulted from inadequate communication or explanations. The committee strongly urges better communication between physicians and patients.

As chairman, I thank the committee members for helping resolve these problems.



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### INDIANA MEDICINE

**George T. Lukemeyer, M.D.,**  
editorial board chairman

The editorial board of *Indiana Medicine* reviewed 18 manuscripts from Aug. 1, 1994, to July 31, 1995. All manuscripts are reviewed by one or more members of the editorial board to determine their acceptability for publication. Some articles are also submitted to outside reviewers.

I would like to thank the following editorial board members for their assistance in reviewing manuscripts: Thomas J. Conway, M.D., Terre Haute; James W. Edmondson, M.D., Indianapolis; Robert L. Forste Jr., M.D., Colum-

bus; Panayotis G. Iatridis, M.D., Gary; George C. Manning, M.D., Fort Wayne; Barney Maynard, M.D., Evansville; Martha Mechei, M.D., Hammond; and Bruce F. Waller, M.D., Indianapolis. I also appreciate the participation of Theresa Bayt and John Joven, the student representatives on the board.

The editorial board met April 12, 1995, at the ISMA office. Members discussed ideas for future articles in *Indiana Medicine* and reviewed recent articles submitted for publication.

The first annual Frank B. Ramsey Medical Writing Award was presented to Gary J. Keepes, M.D., now a family practice

resident in Evansville. The winner was announced at the annual ISMA convention in October 1994, and Dr. Keepes's paper, "Survey of Influencing Factors to a Career in Family Medicine," was published in the January/February 1995 issue of *Indiana Medicine*. Established at the recommendation of the editorial board, the award honors the memory of Frank B. Ramsey, M.D., the editor of *Indiana Medicine* from 1949 to 1990. It will be given annually to a student at the Indiana University School of Medicine. The medical school faculty selects three finalist papers, which then are reviewed by the editorial board to determine the award winner, who receives \$500. □



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## Status of 1994 resolutions

### RESOLUTION 94-2

#### **Including Gram Stain in a Physician's Armamentarium**

Introduced by: Bernard J. Emkes, M.D.  
Referred to: AMA delegation  
Status: Introduced as Resolution 219 and adopted at the I-94 AMA Meeting.

### RESOLUTION 94-3

#### **Tax-Exempt Hospitals Competing Against Tax-Paying Health Care Providers**

Introduced by: Vigo, Parke, Vermillion  
County Medical Societies  
Referred to: ISMA Board of Trustees  
Status: The ISMA Board of Trustees met May 7, 1995, and tabled indefinitely any action on this resolution until further information becomes available.

### RESOLUTION 94-4

#### **Prohibit Corporal Punishment in Indiana Schools**

Introduced by: John W. Luce, M.D., LaPorte County  
Referred to: ISMA Legislation Department  
Status: No legislative author was found.

### RESOLUTION 94-5

#### **Financial Compensation to Primary Care Physicians Who Provide Training for Physicians in Training**

Introduced by: ISMA Subcommittee on Accreditation and Commission on Medical Education  
Referred to: ISMA Legislation Department  
Status: Currently provided for in budget bill.

### RESOLUTION 94-6

#### **Medical Licensing Board Registration Fees**

Introduced by: ISMA Executive Committee  
Referred to: ISMA Legislation Department  
Status: Legislative study committee report was inconclusive. Report was submitted to ISMA Commission on Legislation.

### RESOLUTION 94-7

#### **Indiana Medical Oncology Society**

Introduced by: Robert T. Woodburn, M.D., President, Indiana Medical Oncology Society  
Referred to: ISMA Commission on Constitution and Bylaws for implementation  
Status: Implemented.

### RESOLUTION 94-9A

#### **Tougher Licensing Laws for Sale of Tobacco**

Introduced by: Third District Medical Society  
Referred to: ISMA Legislation Department and AMA delegation for introduction at the A-95 AMA meeting  
Status: Legislation introduced but did not receive a committee hearing. The AMA delegation introduced Resolution 401 at the June 1995 AMA Annual Meeting. The following substitute Resolution 401 was adopted:

"Resolved, That our American Medical Association seek and support legislation that would restrict the display of tobacco products and would permit sales of tobacco only with the assistance of a sales person; and be it further

Resolved, That our AMA work with the Federation to seek implementation of laws based on existing model state legislation 'To Prohibit the Sale to or Purchase of Tobacco Products by Individuals Under 21 Years of Age'; and be it further

Resolved, That our AMA encourage strict enforcement of existing laws to restrict access to tobacco products by individuals under the age of 21; and be it further

Resolved, That Policies 505.973, calling for bans on vending machines for tobacco products and 505.990, calling for model legislation to restrict children's access to tobacco, be reaffirmed."

## RESOLUTION 94-11

Introduced by:  
Referred to:

**Dues Delinquent Members**  
ISMA Executive Committee  
ISMA Commission on Constitution and Bylaws for implementation  
Implemented.

Status:

## RESOLUTION 94-12

Introduced by:  
Referred to:  
Status:

**AMA Fiscal Note Accountability**  
Barney R. Maynard, M.D., District 1 Trustee  
AMA delegation  
Introduced Resolution 607 at the I-94 AMA meeting; adopted first resolve and rejected second resolve.

## RESOLUTION 94-14

Introduced by:  
Referred to:  
Status:

**Good Samaritan Statute**  
ISMA Board of Trustees  
ISMA Legislation Department  
Legislation passed the Indiana General Assembly and was signed by the governor.

## RESOLUTION 94-15A

Introduced by:  
Referred to:  
Status:

**Protection of Patient Rights**  
Vanderburgh County Medical Society  
ISMA Legislation Department  
Legislation introduced but was not approved in committee.

## RESOLUTION 94-16

Introduced by:  
Referred to:  
Status:

**Medical Relief Task Force**  
Lawrence Bailey, M.D., Dearborn/Ohio County Medical Society  
ISMA Board of Trustees  
Survey sent with May *ISMA Reports*. More than 600 ISMA members indicated an interest. A task force will be appointed to determine the next step.

## RESOLUTION 94-17

Introduced by:  
Referred to:  
Status:

**Civil Immunity Law**  
Fort Wayne Medical Society  
ISMA Legislation Department  
Legislation passed the Indiana General Assembly and was signed by the governor. The bill allows local units of government to indemnify care rendered in free clinics.

## RESOLUTION 94-18

Introduced by:  
Referred to:  
Status:

**Clinical Laboratory Accreditation Through COLA**  
Robert Rudesill, M.D., Indiana Society of Internal Medicine  
ISMA Communications Department  
The ISMA is now on COLA's media list; information forthcoming will be published in *ISMA Reports* and *Indiana Medicine*.

## RESOLUTION 94-19

Introduced by:  
Referred to:  
Status:

**An American Concept for Responsible Health Care Funding**  
Kenny E. Stall, M.D., Franklin  
ISMA Board of Trustees  
A conference call meeting of the ISMA Health System Task Force was held. The task force recommends that the plan not be pursued at this time.

## RESOLUTION 94-21A

Introduced by:  
Referred to:  
Status:

**Federal Tax Credit for Charity Care**  
Gregg A. Dickerson, M.D., Muncie  
ISMA Board of Trustees  
The board voted on May 7, 1995, to take no further action due to existing AMA policy.

## RESOLUTION 94-22

Introduced by:  
Referred to:  
Status:

**Third-Party Coverage for Mental Illness**  
John J. Wernert III, M.D., Indiana Psychiatric Society  
ISMA Legislation Department  
Legislation heard in Indiana House of Representatives but



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failed to pass committee due to opposition from insurance industry and Indiana Chamber of Commerce. The Indiana Commission on Mental Health will study this issue.

### RESOLUTION 94-23

#### **Medical Care Reimbursement by Medicare and Medicaid**

Introduced by: Lake County Medical Society  
Referred to: ISMA Practice Management Consultants for implementation  
Status: The ISMA presented testimony to the House Public Health Committee.

### RESOLUTION 94-25

#### **Changes in the Indiana Medical Licensing Board Emergency Procedures**

Introduced by: Lake County Medical Society  
Referred to: ISMA Legal Counsel and ISMA Legislation Department  
Status: Legislation passed the Indiana General Assembly and was signed by the governor.

### RESOLUTION 94-28

#### **Equitable Reimbursement**

Introduced by: Indiana Academy of Family Physicians  
Referred to: ISMA Practice Management Consultants for implementation  
Status: Attempts to secure a state-wide payment locality have not yet been successful.

### RESOLUTION 94-29

#### **Advanced Practice Nurses**

Introduced by: Indiana Academy of Family Physicians  
Referred to: ISMA Legislation Department  
Status: No legislation affecting advance practice nurses was introduced this session.

### RESOLUTION 94-30A

#### **Injection of Medicine by Syringe/Needle by Paramedical Personnel**

Introduced by: William R. Vaughn, M.D.  
Referred to: ISMA Legislation Department  
Status: No legislation sought, due to commitments obtained by Indiana Academy of Ophthalmology and the Optometric Legend Drug Prescription Advisory Committee.

### RESOLUTION 94-31

#### **The Physicians' Response to Family Violence**

Introduced by: ISMA/ISMA Alliance Family Violence Task Force  
Referred to: ISMA Communications Department  
Status: Action plan prepared for continuing activities. News release was mailed to hospital newsletters in December that listed the protocols for recognizing and treating victims of family violence. The same information was included in the winter *News & Notes* poster and in the February *ISMA Reports*. Speakers continue to be scheduled on topic. Update of activities by county societies included in May *ISMA Reports*. Sent news releases to Southeast Indiana media regarding Fourth District Medical Society contribution of \$1,000 to Turning Point, a shelter for abuse victims. Article was published in four newspapers.

### RESOLUTION 94-32

#### **Family Violence - Medical School Training**

Introduced by: ISMA/ISMA Alliance Family Violence Task Force  
Referred to: ISMA Communications Department  
Status: Letter was sent to Walter Daly, M.D., indicating that we understand that the medical school has already developed

and begun implementation of additional training.

**RESOLUTION 94-33A** **Negotiating Health Care Levels and Fees Under Managed Care Programs**  
 Introduced by: Lake County Medical Society  
 Referred to: ISMA Legislation Department  
 Status: Legislation introduced but did not pass committee. Federal legislation will be sought by the AMA.

**RESOLUTION 94-34** **Reporting Mechanism for Children Screened for Anemia and Lead**  
 Introduced by: Betty J. Campbell, M.D., Terre Haute  
 Referred to: ISMA Board of Trustees for implementation  
 Status: Information appeared in May/June *Indiana Medicine*.

**RESOLUTION 94-35** **Reporting Mechanisms for Childhood Immunizations**  
 Introduced by: Betty J. Campbell, M.D., Terre Haute  
 Referred to: ISMA Board of Trustees  
 Status: Information has been collected and will appear in the future in *Indiana Medicine*.

**RESOLUTION 94-38** **Physician Provider and Insurance Payer Communication**  
 Introduced by: Herbert Trier, M.D., Fort Wayne  
 Referred to: ISMA Board of Trustees  
 Status: ISMA staff will continue to monitor the situation.

**RESOLUTION 94-39** **AMA Position on Gun Control**  
 Introduced by: Rick Robertson, M.D., Indianapolis  
 Referred to: AMA delegation at the I-94 AMA meeting  
 Status: Introduced (Resolution 218) at the I-94 AMA meeting; rejected first resolve, added a portion of second resolve: "support scientific research

and objective discussion aimed at identifying causes of and solutions to the crime and violence problem" to AMA Policy 145.986.

**RESOLUTION 94-40** **Medicaid Reform**  
 Introduced by: John McGoff, M.D., American College of Emergency Physicians, Indiana chapter  
 Referred to: ISMA Board of Trustees  
 Status: Pursued and implemented by resolution sponsor, John McGoff, M.D.

**RESOLUTION 94-41** **All-Rider Helmet Use Mandate**  
 Introduced by: John McGoff, M.D., American College of Emergency Physicians, Indiana chapter  
 Referred to: ISMA Legislation Department  
 Status: No legislative author could be found.

**RESOLUTION 94-42** **Domestic Violence**  
 Introduced by: John McGoff, M.D., American College of Emergency Physicians, Indiana chapter  
 Referred to: ISMA Legislation Department  
 Status: Domestic violence legislation was enacted during the 1995 legislative session.

**RESOLUTION 94-43** **Poison Control Centers**  
 Introduced by: John McGoff, M.D., American College of Emergency Physicians, Indiana chapter  
 Referred to: ISMA Legislation Department  
 Status: Funding currently provided for in the state budget bill.

**RESOLUTION 94-44** **Inclusion of "Any Willing Provider" and "Freedom of Choice" in any Health Care Reform Legislation**  
 Introduced by: Indiana Society of Internal Medicine  
 Referred to: ISMA Legislation Department  
 Status: No legislation was passed that would compromise our "any willing provider" law.

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### RESOLUTION 94-45

Introduced by:

Referred to:

Status:

#### **Radiation Oncology Section**

Madison County Medical Society

ISMA Commission on Constitution and Bylaws for implementation

Implemented.

### RESOLUTION 94-46

Introduced by:

Referred to:

Status:

#### **Ad Hoc Task Force on Managed Care**

C.M. Hocker Jr., M.D., Secretary, Floyd County Medical Society

ISMA Legal Counsel and ISMA Communications Department

Committee is working on information packet to be available to 1995 House of Delegates.

### RESOLUTION 94-47

Introduced by:

Referred to:

Status:

#### **HHS, HCFA, Medicaid, PRO, the Indiana State Department of Health and JCAHO Regulation**

Robert J. Steele, M.D., Kokomo

ISMA Legislation Department for implementation

The ISMA has worked to educate state legislators by providing testimony on this matter before several committees. Further, the ISMA provided testimony before a federal Congressional subcommittee chaired by Rep. David McIntosh (R-Ind.). □





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# 1995 ISMA Digest of Health & Medical Laws

The 1995 Indiana legislative session was one of the more controversial sessions in recent history. A very large number of divisive issues were taken up by Indiana legislators. Most of those issues had nothing to do with health care, but the political spin-off certainly had an impact on how medicine's issues fared in the process. Issues such as legislative redistricting (Republican vs. Democrat), prevailing wage (state chamber of commerce vs. labor unions), teachers unions (Republicans and others vs. Indiana State Teachers Association), and others caused a great deal of consternation within the legislature.

Through it all, the Indiana State Medical Association fared quite well. Most of the issues we opposed were steered off path relatively early in the session. For example, language to allow pharmacists to participate in drug therapy management was deleted from Senate Bill 554 during the first committee stage of the process. While the bill eventually became law, the language ISMA opposed was not a part of the final version of the bill. Other bills that we opposed will be found in the "Morgue" section of this publication.

The success of this legislative session was a function of the terrific way in which Indiana physicians responded to the calls to action and the legislative newsletter requests for action. To those who took the time to write, call, or visit your legislator, we say "thank you." We will need you again next year!

If you have any questions or comments about the bills summarized in this document, please feel free to call upon ISMA's staff, who stand ready to answer your questions.

**Barney Maynard, M.D.**

Chairman, ISMA Commission on Legislation

**Michael Abrams**

Director, Government Relations

**Lou Belch**

Assistant Director, Government Relations

**Katherine Vaughn**

Legislative Liaison

**Debbie Warner**

Administrative Assistant

### **Senate Enrolled Acts**

All enrolled acts are effective July 1, 1995, unless otherwise noted.

#### **SEA 76**

Authors: Riegsecker, Landske, Lubbers

Sponsors: Buck, Crawford, Warner, Budak

- Allows a unit of state or local government to purchase professional liability insurance for a medical clinic or health care facility that provides health care to individuals without compensation.
- If liability insurance is purchased for the free clinic by a unit of government, then a health care provider who voluntarily and without compensation provides health care services to patients at the free clinic is immune from civil liability while providing those services.

#### **SEA 89**

Author: Miller

Sponsors: Murphy, Heeke

- Changes the expiration date for the family and social services administration from July 1, 1995, to July 1, 1997.
- Requires Medicaid to reimburse for physician services provided in an emergency department of a hospital to enrollees in the Primary Care Case Management Program. The reimbursement shall be calculated using the same methodology used to calculate other physician reimbursement. Payment is made for CPT codes 99281, 99282 or 99283 without prior approval.
- Allows retrospective approval by the primary care case manager for other services provided in an emergency department of a hospital.
- Effective upon passage.

#### **SEA 90**

Author: Miller

Sponsors: Frizzell, Alevizos

- Expands the Good Samaritan statute to grant civil immunity to a person who gratuitously renders emergency care at the scene of an emergency.
- Defines "gratuitously renders emergency care" as the giving of emergency care that was volunteered without a legal obligation and without the expectation of remuneration.
- Does not apply to services rendered by a health care provider to a patient in a health care facility.

#### **SEA 261**

Authors: Meeks, Riegsecker, Thompson, Leising, Craycraft, Hellmann, Worman, Zakas, Kenley

Sponsor: Frizzell

- Allows an employer to establish a medical care savings account program, exempt from state tax, to pay for the health care expenses of the employer's employees.
- Allows an employee to withdraw money from a medical care savings account for purposes other than health care expenses; however, the withdrawal will be subject to a penalty equal to 10% of the withdrawal. The penalty shall be deposited into a fund to provide local boards of health with funds to provide public health services.

#### **SEA 311**

Authors: Leising, R. Young, Nugent, L. Hume

Sponsors: M. Young, J. Becker, Wilson, Dobis, Cook, Buck, Heffley, Padfield, Turner, Robbins, Frizzell

- Requires the voluntary and informed consent of a pregnant woman at least 18 hours before an abortion.
- Makes an exception from the informed consent requirement in case of a medical emergency.
- Voluntary and informed consent means the pregnant woman is informed of: the name of the physician performing the abortion; the nature of the proposed procedure or treatment; the risks of and alternatives to the procedure of treatment; the probable gestational age of the fetus; and the medical risks associated with carrying the fetus to term.
- The pregnant woman must also be orally informed: that she may be eligible for Medicaid benefits; that the father of the unborn fetus is legally required to assist in the support of the child (this may be omitted in cases of rape); and that adoption is an alternative and that adoptive parents may legally pay the costs of the pregnancy.
- Failure to provide any of the above information is a Class A infraction.
- Effective September 1, 1995.

#### **SEA 325**

Authors: Adams, Wyss

Sponsors: Kruse, Ayres, V. Smith, Klinker, Moses, Richardson



- Defines "intervention" as activities performed to identify persons in need of addiction treatment services and the referral or enrolling of persons in addiction treatment programs.
- Allows a county fiscal body to pay for intervention services in addition to addiction treatment programs.

### **SEA 383**

Authors: Thompson, Landske, Howard

Sponsors: Behning, Dobis, Foley, Ruppel, Ayres, D. Young, D. Hume

- Changes the method of death for the death penalty from electrocution to lethal injection.

### **SEA 421**

Authors: Johnson, Riegsecker

Sponsors: T. Brown, Crawford

- Establishes the health finance commission to study issues and any administrative rules that pertain to the delivery, payment, and organization of health care services in Indiana.
- Creates the health finance advisory committee to provide information and assist the commission. Requires membership of the advisory committee to include a physician.
- Requires the state health commissioner to submit written comments on each proposed rule promulgated by the office of the secretary of family and social services or by the office of Medicaid policy and planning.
- Effective upon passage.

### **SEA 449**

Author: Worman

Sponsors: Fesko, M. Smith, T. Brown, Denbo

- Defines "member insurer" as a person licensed or certified to transact insurance business in Indiana. This term does not include, among other things, a medical and hospital service organization, an HMO, a prepaid limited health service organization, or a special service health care delivery plan.

### **SEA 478**

Authors: Kenley, Miller, R. Young, K. Smith, Paul, Simpson, Leising

Sponsors: Espich, Budak, Crawford

- Allows the family and social services administration to adopt rules to adjust its programs, including Medicaid and AFDC, to meet funding levels

appropriated by the general assembly.

- Makes a person who commits a misdemeanor ineligible for AFDC and Medicaid for 1 year. Makes a person who commits a felony ineligible for 10 years.
- Places a 24 month lifetime limit on AFDC benefits. This limit also applies to Medicaid when the sole reason for eligibility is eligibility for AFDC. Welfare benefits received in another state in the past 3 years count against this limit. A credit of 1 month of welfare benefits may be earned for each 6 months of employment, up to 24 months of benefits at any time.
- Places a "family cap" on AFDC benefits. Prohibits additional AFDC payments from being granted for a child born 10 months after a family qualifies for assistance, but allows limited vouchers for child care to be granted.
- Makes a person who quits a job or voluntarily reduces hours worked ineligible for AFDC and Medicaid for 6 months.
- Requires all AFDC recipients to sign a personal responsibility agreement. This includes an agreement to ensure that the recipient's children receive all appropriate vaccinations, and that the recipient will not abuse illegal drugs.
- Makes a person who is employed at a wage below 150% of poverty, but not eligible for AFDC, eligible for up to 12 months of Medicaid benefits.
- Requires the mother of an AFDC recipient to execute a paternity affidavit in order to receive benefits. Payment to providers may not be delayed if the mother fails to comply with this section. Requires a person who attends the birth of a child born out of wedlock to provide the mother the opportunity to execute a paternity affidavit.
- Requires recipients of AFDC and Medicaid, when the sole reason for eligibility for Medicaid is eligibility for AFDC, to perform public service in exchange for benefits.
- Prohibits this act from being construed to limit Medicaid assistance to pregnant women and children (SOBRA recipients), disabled persons under age 18, and supplemental security income recipients.
- Allows the Medicaid office to means-test for benefits to SOBRA recipients, but makes an exemption for an automobile valued at less than \$4500.

- Makes refugees fully eligible for welfare. Makes lawful permanent residents eligible for 1 year of welfare and 1 year of transitional benefits. Makes illegal aliens ineligible for any welfare assistance.
- Makes a provider convicted of Medicaid fraud ineligible to participate in Medicaid for 10 years.
- Allows a township trustee to refuse to provide poor relief to an applicant who has been denied welfare benefits.
- Prohibits an insurer from denying health care coverage to a child who is born out of wedlock, who is not claimed as a dependent of the parent, or who does not reside with the parent. When a court orders health coverage by a noncustodial parent, it requires the insurer to enroll the child without regard to enrollment periods, and requires the insurer to accept an enrollment by the child's custodial parent if the noncustodial parent fails to apply for the coverage.
- Makes various other changes to the welfare law.

#### **SEA 479**

Authors: Worman, Lewis

Sponsors: Fesko, Harris

- Requires an individual who acts as a medical claims review consultant to register with the department of insurance under the medical claims review statute.
- Health care providers who receive less than \$5,000 annually for review of claims are exempted.

#### **SEA 480**

Authors: Worman, O'Day

Sponsors: M. Smith, Fry, Fesko, Pond

- Defines "managed hospital payment basis" under the HMO laws as agreements in which the financial risk is primarily related to the degree of utilization rather than to cost of services.
- Provides that an HMO authorized to do business in Indiana is subject to the laws relating to unfair methods of competition and unfair or deceptive acts or practices under the insurance statute, unless those laws conflict with HMO laws, in which case the HMO laws govern.

#### **SEA 519**

Author: Merritt

Sponsor: Ruppel

- Defines "basic life support" to include procedures

contained in the revised *National Emergency Medical Technicians Basic Training Curriculum Guide*.

- Requires the emergency medical services commission to appoint an advanced life support operations sub-committee to advise the commission on the development of certification requirements for: provider organizations, paramedics, advanced emergency medical technicians and supervising hospitals.
- Prohibits individuals, except licensed health care providers, from providing advanced life support services unless they hold a certificate issued by the commission.

#### **SEA 560**

Author: Worman

Sponsors: Fesko, Fry

- Prohibits managed care organizations from refusing to enter into an agreement with a hospital based solely on the fact that the hospital has not obtained accreditation from the Joint Commission for the Accreditation of Health Care Organizations.

#### **SEA 576**

Authors: Miller, K. Smith, Kenley, Riegsecker, Simpson, Zakas

Sponsors: V. Becker, T. Brown, Crawford, Budak

- Allows an employer to establish a medical care savings account program, exempt from state tax, for the benefit of the employer's employees.
- Requires the state department of health, with the Medicaid office, to establish demonstration projects to enroll designated Medicaid recipient populations in private insurance programs. (Effective upon passage.)
- For an individual health insurance policy, limits a preexisting condition waiting period to 12 months before and 18 months after the effective date of the policy. Effective January 1, 1998, limits the waiting period to 12 months before and after the effective date of the policy.
- Prohibits an employee of an employer who offers an ERISA health plan to its employees from being placed in or referred to the Indiana Comprehensive Health Insurance Association. (Effective upon passage.)
- Expands the application of Indiana's small group health insurance law from employers with 3-25



employees to employers with 3-50 employees.

- For small group plans, limits a preexisting condition waiting period to 9 months before and 9 months after the effective date of the policy. Provides that an individual who is continuously covered with a lapse of no more than 30 days cannot be required to serve a waiting period more than once.
- Allows an individual who loses coverage due to termination of employment to purchase an individual conversion policy at no more than 150% of the former employer's group plan rate.
- Effective January 1, 1998, allows former employees the option of purchasing a continuation policy at 102% of the group plan rate to remain under the former employer's plan for up to 12 months. After the 12 months expires, the former employee may then purchase a conversion policy at 135% of the group plan rate. *(This section applies only if the general assembly enacts a mechanism to offset the potential fiscal impact on small employers and insurers that results from the establishment of a continuation policy.)*
- Provides that if an employee joins an employer group after the employer has become insured under a health plan, the new employee and any dependents of the employee must also be granted coverage.
- Requires that an insurer who agrees to insure a group must provide coverage for the whole group, no members excluded.
- Prohibits an insurer from refusing to insure a group based solely on the nature of the small employer's business.
- Creates a study commission to outline a plan for providing health care coverage for the working poor. (Effective upon passage.)
- All sections of this act are effective January 1, 1996, unless otherwise noted.

#### **SEA 618**

Authors: Server, Simpson

Sponsors: Lambert, Heeke, V. Becker, J. Hays

- Requires an insurance policy that covers anesthesia services by a physician to also cover those services if the care is provided by a certified registered nurse anesthetist.

#### **SEA 656**

Author: Riegsecker

Sponsor: Keeler

- Adds to the peer review statute a nonprofit health care organization affiliated with a hospital that is owned or operated by a religious order, whose members are members of that religious order.

#### **SEA 658**

Authors: Wheeler, Miller

Sponsors: Espich, Fry

- Defines a health care review committee in an HMO or PPO setting as a peer review committee.
- Requires the HMO or PPO to give a health care provider an evidentiary hearing before taking corrective action against or terminating the provider based upon an evaluation of patient care.

#### **House Enrolled Acts**

All enrolled acts are effective July 1, 1995, unless otherwise noted.

#### **HEA 1006**

Authors: Espich, Budak, D. Young

Sponsors: Johnson, Simpson

- Allows the court to order a person's professional or occupational license, certificate, registration, or permit to be placed on probationary status if the person is delinquent in the payment of child support.
- If the person is still delinquent in payment 20 days after notice of the probation is mailed, the board regulating that person's profession shall suspend the person's professional or occupational license, certificate, registration, or permit.
- Requires that the probation or suspension may not terminate until 10 business days after the board regulating the person's profession or occupation receives a notice from the child support bureau that the person has paid the child support obligation in full or arranged for income withholdings to make the payments.
- Allows the court to order a person's driver's license to be suspended if the person is delinquent in the payment of child support. Violation of the suspension is a Class A infraction.
- Allows a restricted driving permit to be granted under certain circumstances.
- Reinstatement of the person's driver's license may not be granted until the person has paid the child support obligation in full or arranged for income



withholdings to make the payments.

- Effective October 1, 1995.

#### **HEA 1027**

Authors: Kruse, Turner

Sponsors: Worman, Lewis

- For an individual health insurance policy, makes coverage by the insurer optional for a newly born child of an insured if the pregnancy resulting in the birth of the child was a preexisting condition.
- Requires the insurer's decision of whether to cover the newly born child to be based on standard underwriting practices.

#### **HEA 1090**

Authors: Grubb, V. Becker, T. Brown

Sponsors: Miller, Breaux

- Requires the bureau of motor vehicles to place an identifying symbol on the face of a driver's license to indicate that an executed anatomical gift form is located on the back. (Effective July 1, 1996.)
- Adds grandparents to list of individuals who may consent to the donation of organs in the absence of any stated wishes by the decedent.
- Allows an individual to indicate a desire to refuse to make an anatomical gift in the same manner the individual can indicate a desire to make a gift, including on the driver's license.
- If the anatomical gift is indicated on the back of a driver's license, legal revocation of the license does not revoke the gift.
- Requires hospitals to make a reasonable search for information to determine if an individual is an organ or tissue donor, or if the individual has refused to make an anatomical gift. Requires this search to be done upon admission of an individual at or near the time of death.
- Allows a coroner to release a body or part of a body in the coroner's possession if the removal will not interfere with any autopsy or investigation.
- Requires the state department of health to develop educational materials about the transmission of HIV prenatally and neonatally. The department shall promote the use of the materials by health care providers.

#### **HEA 1127**

Authors: V. Becker, Ayres, Kruzan, Budak, Steele, Kruse, Turner

Sponsors: Merritt, Landske, K. Smith, Zakas

- For a second offense on the violation of a protective order, if the violation resulted in bodily injury to the petitioner (protected person), requires the court to order the offender to serve a 5-day, non-suspendable prison sentence.

#### **HEA 1206**

Author: V. Becker

Sponsor: Miller

- Makes a uniform 10 calendar day period to allow an individual or entity to respond to an inspection report of the state department of health.
- Except when there is an imminent threat to health and safety, prohibits an inspection report from being made public for 10 calendar days.

#### **HEA 1325**

Authors: Goeglein, Becker

Sponsors: Riegsecker, Wyss, Smith

- Defines "primary caregiver" as an individual who provides for the physical, emotional, and social needs of another individual who cannot provide for their own needs.
- Adds primary caregiver to the list of individuals who may, upon written request, receive information regarding mental health services delivered to the patient.

#### **HEA 1352**

Authors: Behning, Womacks, Frizzell

Sponsors: Lubbers, Breaux, Rogers

- Requires the division of family and children to establish a pilot program for delivering benefits to AFDC clients in up to 5 counties. Requires the pilot program to include two client groups, one to receive privatized delivery of services and one to remain under the current AFDC system.
- Requires the division to compare overall costs, client satisfaction, success, and timeliness of service delivery between the two groups and report this information to the general assembly.

#### **HEA 1382**

Authors: V. Becker, Budak, Dickinson, Fry

Sponsors: Server, K. Smith, Breaux, Howard, Leising, Rogers, Gard, Dempsey, Zakas

- Gives local area agencies on aging the responsibility for case management for eligible individuals requiring long term care services.

- Defines "eligible individual" as a person unable to perform 2 or more activities of daily living, as described on the long term care services eligibility screen.
- Requires the division to publish a copy of the screen in the *Indiana Register* and to make copies of the screen available to the public upon request.
- Requires the division to conduct a survey of the CHOICE program and to conduct certain studies about the CHOICE program and other long term care programs for a report to the general assembly.

### **HEA 1383**

Author: V. Becker

Sponsors: Server, Simpson

- Prohibits the corporate practice of medicine by HMOs. Specifies that an HMO may hire a physician, but that the HMO may not exercise control over the independent medical judgments of the physician.

### **HEA 1446**

Authors: Buck, T. Brown, Stevenson, Duncan

Sponsor: Johnson

- Requires an individual who has a medical condition that causes the individual to appear intoxicated to have a distinctive color coding on the face of their driver's license.
- A physician must provide a verified certificate attesting the individual's medical condition.
- Effective January 1, 1996

### **HEA 1571**

Authors: Keeler, Fry

Sponsors: Clark, L. Hume, Randolph, Howard

- Provides that an employer who provides certain benefits to an employee, including health insurance or disability benefits, has an insurable interest in the life of the employee.
- Allows an employer to acquire insurance upon an employee in whom the employer has an insurable interest if the employee consents to be insured. Consent means the employee is given written notice of the insurance coverage and has not objected to the coverage within 30 days of receipt of the notice.

### **HEA 1598**

Authors: Bosma, Crawford, Alderman

Sponsor: Miller

- Provides that the office or practice of a physician or group of physicians that is owned by a hospital is not exempt from property tax unless the office or practice: is substantially related to or supportive of the inpatient facility; or provides or supports the provision of charity care; or provides or supports the provision of community benefits including research, education, or government-sponsored indigent health care.
- Participation in the Medicaid or Medicare program, alone, does not entitle an office or practice owned by a hospital to be exempt from property tax under this section.

### **HEA 1623**

Author: Frizzell

Sponsors: Riegsecker, Smith, Wheeler, Lewis

- Requires the attorney general to make a reasonable attempt to notify a physician before the medical licensing board may suspend the physician's license.
- Allows a physician to make a written or oral statement during the suspension hearing.
- Permits the attorney general to hire clinical consultants to assist with investigations.
- Requires the medical licensing board to make a recommendation to the attorney general regarding medical malpractice information received by the board from the department of insurance.

### **HEA 1695**

Authors: Crawford, V. Becker, C. Brown, D. Young

Sponsor: Howard

- Adds Latinos and Pacific Islanders to the groups studied by the Interagency State Council on Black and Minority Health.
- Requires at least one member of the council to be a member of the Indiana Minority Health Coalition.
- Adds to the duties of the council the examination of the impact of intentional injuries, accidental injuries, HIV and AIDS, disability and aging, and sickle cell anemia on minorities.
- Requires the council to monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.

### **HEA 1703**

Authors: Warner, Cook

Sponsors: Riegsecker, Adams, Wolf



- Allows a township executive to pay township funds to support a drug awareness program in a school.

#### **HEA 1718**

Authors: Gulling, Ruppel

Sponsor: Meeks

- Requires a prisoner in the department of corrections to make a \$10 dollar co-payment for non-emergent medical services.

#### **HEA 1752**

Authors: Frizzell, Kruse, Duncan, Crawford, C. Brown

Sponsor: Johnson

- Requires a physician making a determination of medical disability for the purpose of an individual qualifying for Medicaid to make the determination without reference to the individual's ability to pay for treatment.
- Makes changes to the law on recoveries by the Medicaid office of claims filed against the estate of a surviving spouse.
- Provides that if the office believes that overpayment to a Medicaid provider has occurred, the office may notify the provider and request repayment of the alleged overpayment. Upon receipt of such notice, allows the provider to elect to repay the amount, with interest, within 60 days; request a hearing and repay the amount, with interest, within 60 days; or request a hearing and not repay the amount. (Effective retroactively.)
- Provides that if a hearing is requested and the provider has repaid the alleged amount, and the office determines after the hearing that the provider does not owe the alleged amount, the office shall return the amount of the alleged overpayment, with interest. Provides that if a hearing is requested and the provider has not repaid the alleged amount, and the office determines after the hearing that the provider does owe the alleged amount, the provider shall pay the amount of overpayment, with interest.
- Allows a hospital that receives a notice and request for repayment from Medicaid to have 180 days to elect one of the above actions. (Effective retroactively.)
- Makes changes to the method of payment for nursing facility services under Medicaid. (Effective upon passage.)

- Increases Medicaid nursing facility staffing limits.
- Expands the Medicaid nursing facility extensive care criteria to include high-intensity rehabilitation residents.
- Requires a criminal history check for each nurse aide and other unlicensed employee of a health facility or hospital-based health facility. Prohibits the employment of a nurse aide or other unlicensed employee at a health facility or hospital-based health facility who has been convicted of rape, criminal deviate conduct, exploitation of an endangered adult, a felony offense related to controlled substances in the past 5 years, or various other offenses.
- Knowingly applying for one of the above jobs after one of the above convictions is a Class A infraction. Operating a health facility or administering a hospital-based health facility and knowingly failing to obtain a criminal history on an applicant or knowingly hiring an applicant with any of the above convictions is a Class A infraction.

#### **HEA 1758**

Authors: V. Becker, Scholer, Crawford, Budak

Sponsor: Miller

- Establishes a 15-member family and social services committee that must approve all rules established by the family and social services administration before the rules may take effect. A majority of the committee members may not have a fiduciary interest in any agency program. One member of the committee must be a physician.
- Requires Medicaid providers to be given 45 days notice of any change to the Medicaid program. (Effective upon passage.)
- Establishes the Medicaid clinical advisory committee. Requires Medicaid to obtain the input of the advisory committee before making any changes to medical policy for the Medicaid program. (Effective upon passage.)

#### **HEA 1772**

Author: M. Young

Sponsor: Harrison

- Requires worker's compensation claims be paid at the 80th percentile of all claims in the same geozip area. "Geozip" is defined as the first three digits of the zip code.
- Requires that data used to determine the 80th percentile must be no older than two years and



must be adjusted for inflation or deflation.

- Requires that hospital information must be included in the data base.
- Allows a medical service provider to request an explanation if the provider's bill has been reduced as a result of the application of the 80th percentile or a CPT coding change.
- Allows the worker's compensation board to assess a civil fine between \$100 to \$1000 to a medical service provider who knowingly bills a worker's compensation patient.

### **1995 Legislative Morgue**

The following is a partial list of bills that did not pass during this year's legislative session.

#### **Senate Bill 17**

Author: Meeks

Summary: Certification of hypnotists.

#### **Senate Bill 29**

Author: Randolph

Summary: Increases the penalty for Medicaid fraud to a Class C felony or a Class B felony if the amount received as a result of committing the fraud is at least \$100,000.

#### **Senate Bill 64**

Authors: Gard, Wyss

Summary: Increases the penalty for operating a vehicle while intoxicated if the offender is operating the vehicle with a minor or disabled person as a passenger.

#### **Senate Bill 99**

Author: Howard

Summary: Hospice licensure.

#### **Senate Bill 136**

Author: Craycraft

Summary: Provides that a woman commits a Class D felony if she knows or should reasonably know she is pregnant and knowingly or intentionally ingests a controlled substance without a valid prescription.

#### **Senate Bill 204**

Author: Alexa

Summary: Zero tolerance bill. Makes it a Class C infraction for a person under 18 with a blood alcohol

content of more than 0.01% to operate a vehicle.

#### **Senate Bill 285**

Author: Hellmann

Summary: Adds "any other infectious disease or blood borne pathogen" to the list of diseases that require the attending physician to attach to the deceased body a notice to observe body fluid precautions.

#### **Senate Bill 299**

Author: Riegsecker

Summary: Provides that a person who distributes cigarettes from a vending machine commits a Class C infraction if a person under 18 purchases cigarettes from the machine. Requires a retailer to display tobacco products in an area accessible only to an employee.

#### **Senate Bill 302**

Author: Riegsecker

Summary: Provides that a person who sells tobacco products to an individual under 18 years of age commits a Class C infraction.

#### **Senate Bill 321**

Author: Clark

Summary: Prohibits the transmitting of radiological images outside Indiana for diagnosis of a medical radiological procedure unless the receiving physician holds an Indiana license. Excludes consultations, images sent as part of the patient's medical record, and images sent for educational purposes.

#### **Senate Bill 396**

Author: Randolph

Summary: Requires a health care provider who is responsible for the primary health care of a child between age 6 months and 6 years of age to conduct periodic blood lead testing on the child.

#### **Senate Bill 422**

Author: Miller

Summary: Patient Protection Act. Requires insurers to disclose, in easily understandable language, what is covered under an insurance policy. Requires disclosure of selection criteria used to determine provider participation on managed care panels. Sets up due process requirements for providers discharged from or refused admission to managed care panels. Requires

all insurance products that restrict a patient's ability to choose their own health care provider to provide a point of service options. Requires a health insurance company to disclose any provider incentive plans.

#### **Senate Bill 510**

Author: Thompson

Summary: Requires that all areas of a public building occupied by an agency of state government be non-smoking.

#### **Senate Bill 526**

Author: Craycraft

Summary: Provides that an adult commits a Class A misdemeanor if the adult knowingly, intentionally, or recklessly puts a loaded handgun or an unloaded handgun along with ammunition in a location where the adult knows or should reasonably know that an unsupervised child is likely to gain access to the gun. Makes a repeat offense a Class D felony.

#### **Senate Bill 539**

Author: Wyss

Summary: Reduces from 0.10% to 0.08% the blood alcohol content that is necessary to constitute *prima facie* evidence of intoxication in a prosecution for operating a motor vehicle or watercraft while intoxicated.

#### **Senate Bill 540**

Author: Sinks

Summary: Prohibits corporal punishment in public schools unless the governing body of a school corporation adopts a formal written policy concerning the use of corporal punishment.

#### **Senate Bill 551**

Author: Breaux

Summary: Mandatory premarital HIV tests.

#### **Senate Bill 563**

Authors: Miller, Howard

Summary: Licensure of birthing centers.

#### **Senate Bill 564**

Author: Miller

Summary: Requires a school to obtain prior written consent from a parent before providing a student with a medical examination, medical treatment or medication, or providing individual counseling on health

concerns.

#### **Senate Bill 569**

Author: Kenley

Summary: Physician antitrust relief. Allows physicians to apply for approval to enter into cooperative agreements if the probable benefits resulting from the agreements outweigh the disadvantages from a reduction in competition. Requires the state department of health to approve applications for the collaborations and to periodically review approved collaborations.

#### **Senate Bill 595**

Author: Nugent

Summary: Preempts all local ordinances dealing with the sale, distribution, use, promotion or display of tobacco products. Prohibits law enforcement from employing a minor to test for compliance with the law prohibiting the sale of tobacco products to minors.

#### **Senate Bill 626**

Author: Riegsecker

Summary: Provides a tax credit for prescription drug expenditures for the low income elderly.

#### **Senate Bill 654**

Author: Skillman

Summary: Provides that operation of a truck with a person less than 18 years of age in the open bed of the truck is a Class C infraction. Provides exceptions for parades, certain farm operations, and certain truck beds equipped with seats and seat belts.

#### **House Bill 1034**

Author: Kruse

Summary: Allows a student to be excused from acquired immune deficiency syndrome (AIDS) instruction upon written objection on the basis of conflict with beliefs.

#### **House Bill 1039**

Author: Kruse

Summary: Makes tobacco possession by a minor a Class C infraction. Creates certain exceptions for persons working in tobacco-related businesses.

#### **House Bill 1076**

Author: V. Becker

Summary: Requires individuals applying for a marriage license to sign a statement acknowledging

that Indiana law prohibits a person from abusing or harassing another person and that rape and sexual battery between married individuals is a criminal offense.

#### **House Bill 1085**

Author: Linder

Summary: Requires a local health officer who is aware that a carrier of tuberculosis in a communicable stage or another dangerous communicable disease is enrolled as a student or is employed at a public school to initiate the notification of certain persons, including school employees and the parent or guardian of each student.

#### **House Bill 1169**

Author: Goeglein

Summary: Allows a court to order the division of mental health to pay for the care of mentally ill persons when assistance is not available from other sources.

#### **House Bill 1208**

Author: M. Smith

Summary: Requires the attorney member of a medical review panel in a medical malpractice complaint to select the three health care provider members of the panel. (Current law permits the parties to the complaint to each select one health care provider member and the remaining member of the panel to be selected by the two health care provider members selected by the parties.)

#### **House Bill 1329**

Author: Munson

Summary: Provides that the delivery or financing of the delivery of cocaine or a narcotic drug to a person who is known or would reasonably be known to be pregnant is a Class A felony. A person commits a Class B felony if she knows or should reasonably know she is pregnant and knowingly or intentionally ingests cocaine or a narcotic drug without a valid prescription.

#### **House Bill 1333**

Author: Robbins

Summary: Requires pharmaceutical manufacturers or wholesalers to offer the drugs to all purchasers on the same terms and conditions.

#### **House Bill 1337**

Author: Robbins

Summary: Requires a physician or other medical official to report to local law enforcement authorities a case where a death is likely to have been caused by the unlawful use of a controlled substance. Failure to make such a report is a Class A misdemeanor.

#### **House Bill 1366**

Author: Warner

Summary: Establishes the local board of health education account within the coroners training and continuing education fund. Provides the funding for the account from 50% of the money deposited in the coroners training and continuing education fund from the fee on death certificates.

#### **House Bill 1380**

Authors: V. Becker, Klinker

Summary: Certification of professional counselors.

#### **House Bill 1415**

Author: Mock, Mangus, Cook, Warner

Summary: Prohibits anonymous reports of alleged child abuse or neglect. Authorizes release to a person accused of child abuse or neglect the identity of the person who reported the alleged child abuse or neglect.

#### **House Bill 1434**

Author: M. Young

Summary: Makes numerous changes to the worker's compensation law. Provides that a person who holds a professional license and knowingly or intentionally uses the persons professional status to assist a claimant in making a fraudulent claim for benefits of services, shall have their license revoked.

#### **House Bill 1436**

Author: Kromkowski

Summary: Allows HMO enrollees to access covered services from a chiropractor.

#### **House Bill 1438**

Author: Kromkowski

Summary: Requires county hospitals to grant staff privileges to chiropractors, dentists, podiatrists. (Current law does not prohibit this.)

#### **House Bill 1440**

Author: Scholer



Summary: Allows the state department of health to create a pilot program allowing up to two collaborations statewide between hospitals in a two-hospital county. Hospitals submitting applications must show that the probable benefits resulting from the agreements outweigh the disadvantages from a reduction in competition. Requires the department of health to approve applications for the collaborations and to periodically review approved collaborations.

#### **House Bill 1454**

Author: Steele

Summary: For a person who has a previous conviction for causing the death of another person when driving while intoxicated, enhances the penalty for driving while intoxicated to a Class C felony and enhances the penalty for causing the death of another person when driving while intoxicated to a Class B felony.

#### **House Bill 1500**

Author: Turner

Summary: Requires adult applicants for AFDC to take a drug test upon applying for assistance and each year after the date of application, and under certain other circumstances. Makes an applicant who tests positive for a controlled substance and who does not have a prescription for the controlled substance ineligible for both AFDC and Medicaid.

#### **House Bill 1530**

Authors: Kruse, Kruzan

Summary: Licensure of direct entry midwives. Requires a direct entry midwife to be at least 21 years of age, have at least a high school diploma or a high school equivalency certificate, complete certain educational and practical licensing requirements, and advise, attend, or assist a woman during normal pregnancy, labor, natural childbirth, and the postpartum period. Establishes a midwife regulatory board. Allows for provisional and apprentice licensing.

#### **House Bill 1556**

Authors: Buell, Becker, Crawford, Klinker

Summary: Reduces the cigarette tax discount that is given to cigarette distributors from 4% to 3%. Requires the revenue from the 1% reduction to be used to fund a community health center program. The program shall fund efforts by local units to plan, establish, or expand community or migrant health centers

that provide comprehensive primary health care services in shortage areas.

#### **House Bill 1564**

Author: Behning, Morris

Summary: Requires insurers to cover biologically-based mental illness in the same manner as other physical illnesses.

#### **House Bill 1652**

Author: Bales

Summary: Provides that a health care provider may not bill a patient or a third party for services provided by a clinical laboratory an amount that is greater than the amount actually billed by the clinical laboratory.

#### **House Bill 1664**

Author: Dickinson

Summary: Enhances the penalty for battery resulting in serious bodily injury from a Class C felony to a Class B felony if the battery is committed on a person less than 13 years of age.

#### **House Bill 1694**

Author: M. Young

Summary: Allows patients to directly access services provided by a physical therapist, without referral by a physician.

#### **House Bill 1700**

Authors: Kruse, Kruzan

Summary: Requires, as a condition of being granted a restricted driving permit after receiving a conviction for driving while intoxicated, that the convicted individual may not operate a motor vehicle unless the motor vehicle is equipped with an ignition interlock device.

#### **House Bill 1740**

Author: J. Hays

Summary: Creates a single payer health delivery system in Indiana.

#### **House Bill 1749**

Author: C. Brown

Summary: Requires that physicians who provide services to Medicaid patients in a medically underserved area of the state be paid a supplemental fee. Requires the general assembly to annually review the supplemental fee and make any necessary changes.

### **House Bill 1795**

Author: Kruse

Summary: Requires local health departments to inspect facilities performing abortions, except hospitals. Requires the institution where the abortion is performed to be a "qualified health care provider" under the malpractice law and have at least \$2,000,000 medical malpractice liability insurance. Provides an exception for an abortion necessary to preserve the life of the pregnant woman. Provides that a physician who performs an abortion in violation of the insurance requirements commits a Class C felony.

### **House Bill 1796**

Authors: V. Becker, Budak

Summary: Establishes state and county child fatality review teams to review each investigation surrounding a child's death that is referred to the coroner or the county team from the state review team or a county health officer. The county review team shall report to the state review team certain information, including the cause of death, the circumstances surrounding the cause of death, and trends and recommendations for preventing child deaths.

### **House Bill 1814**

Author: Budak

Summary: Provides for the licensure of hospices.

## **Index**

Those bills marked with an asterisk (\*) were not successful during the 1995 session of the Indiana General Assembly. Summaries of these bills can be found in the morgue.

### **Abortion**

- Inspection of facilities HB 1795\*
- Insurance requirements HB 1795\*
- Waiting period SEA 311

### **AIDS & HIV**

- Premarital testing SB 551\*
- Excusal from instruction about HB 1034\*

### **Alcohol & Drunk Driving**

- Drug and alcohol addiction services SEA325
- Drunk driving with a minor passenger SB 64\*
- Ignition interlock devices HB 1700\*
- Intoxication level SB 539\*
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- Zero tolerance SB 204\*

### **Antitrust**

- Hospitals HB 1440\*
- Physicians SB 569\*

### **Certification**

- see Licensure and Certification

### **Children**

- Battery of HB 1664\*
- Child abuse, anonymous reports HB 1415\*

- Corporal punishment SB 540\*
- Fatality review teams HB 1796\*
- Handguns SB 526\*
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- Riding in truck beds SB 654\*
- School medical exams SB 564\*
- Support payments, delinquency HEA 1006

### **Communicable Disease**

- see also AIDS & HIV
- Body fluid precautions SB 285\*
- Tuberculosis HB 1085\*

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## Notes



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# Indiana doctor played role in Apollo 13 mission

John R. O'Neill  
*The Indianapolis Star*

You can see Dr. Keith Baird in the background of the photograph, behind the three astronauts who had just cheated death to return to Earth.

The picture was taken at the end of the Apollo 13 mission as astronauts Jim Lovell, Fred Haise Jr. and Jack Swigert stepped from the recovery helicopter onto the deck of the aircraft carrier Iwo Jima.

It now hangs on the wall of Dr. Baird's office in Crawfordsville, where he has practiced medicine since 1972, when he left his job as a NASA flight surgeon.

Each astronaut autographed the photo, and Lovell added an inscription as well.

"To Dr. Keith Baird," he wrote. "Many thanks for all your help on Apollo 13."

That 1970 mission is in the news again, thanks to a new movie starring Tom Hanks as Lovell.

Apollo 13 was to be the third mission to land on the moon. But an oxygen tank explosion changed those plans, and the crew had to improvise just to make it back home. Most power was shut off to conserve it for re-entry, and the temperature in the craft plummeted.

The movie is "an excellent portrayal of the astronauts," said Dr. Baird, who saw it recently. "Jim Lovell is very bright, capable, calm. He's a really good guy."

As lead doctor on the recovery team, Dr. Baird was one of the first people to greet the astronauts after

they splashed down in the Pacific Ocean.

His job was to ride in the helicopter that picked up the astronauts and be ready to treat them on the scene if needed.

He helped each man out of the basket that lifted them up to the helicopter.

"When they opened the hatch, you could see their breath," he said. "They were cold as ice."

Back on the carrier, Dr. Baird examined the men and found their weight loss was about double the average for past missions.

He also discovered Haise had a kidney infection. In the movie, it appears those at Mission Control were aware of this during the flight, but they weren't, Dr. Baird said. It is the only big mistake he spotted in the film.

"I think the movie was very, very accurate," he said. "It did a superb job of taking complex scientific and engineering problems and translating them into understandable language."

Dr. Baird also had performed the final preflight physicals on the crew, then left Cape Kennedy four days before launch so he would be on the aircraft carrier in the Pacific at the time of liftoff. The carrier had to be there in case the mission was aborted right after liftoff.

So Dr. Baird was on the carrier for the entire mission; he was kept informed of the problems "in general terms, but with no details."

After all, he said, he didn't need to know how the ship had become crippled. His job was just to treat the astronauts after they got back. Shortly before splash-



Dr. Baird

down, Dr. Baird added, he got a quick summary from the flight surgeon at Mission Control.

"He said it was cold in the cabin, they didn't drink much water, and they didn't get any sleep," he recalled.

Dr. Baird, an Evansville native, graduated from Wabash College and the Indiana University School of Medicine. He got a job at Grumman Aerospace Corp. "because I love airplanes," he said.

At Grumman, one of his jobs was doing physical exams of pilots who were testing the lunar module, being built by Grumman. That led to a job as a flight surgeon with the National Aeronautics and Space Administration.

In the movie, the flight surgeon at Mission Control is the



target of some barbs from the astronauts. That, too, is rooted in reality, Dr. Baird said.

"A doctor is always an adversary of a pilot," he said. "If they get sick with certain things, they can't fly. And we're the ones who determine that."

For example, astronaut Ken Mattingly was taken off the Apollo 13 mission two days before launch.

He was replaced with Swigert because Mattingly had been exposed to the measles.

But that wasn't Dr. Baird's decision. He already had left for the South Pacific and his small place in history – though at the time, of course, no one was thinking in those terms.

"It was all very interesting," Dr. Baird said. "But going through

it, you don't have time to think about it."

No one plays him in the movie, and no one sought his counsel on the script.

Not that he minds.

"It was a very fun time," he said. "I was just a little cog." □

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# How do you manage the risks of long-term care?

Joel M. Blau, CFP  
AMA Investment Advisors, L.P.

**B**ecause you work hard to attain financial goals, one of the greatest fears is that your money will be used up if you suffer a serious illness. Because of this, many physicians are beginning to look at long-term health care insurance policies to absorb some or all of the expenses for nursing home stays and in home health care.

"Long-term care" (LTC) is the phrase used to describe a variety of services in the area of health, personal care and social needs of the chronically ill or infirmed. Based on various studies, including the American Association of Homes for the Aging, more than 40% of all persons age 65 and over will need long-term care services. These services, which can include nursing homes, have costs ranging from \$10,000 to \$80,000 per year, according to *D&B Reports*. Unfortunately, LTC is the largest unfunded health risk facing individuals today as well as the greatest threat to your savings and assets that you have worked so hard to accumulate. Many believe Medi-

care and Medicaid will foot the bill for LTC services. Medicare pays only about 2% of long-term care costs, while Medicaid may pay approximately 41%. The Medicaid portion is available only after "spending down" your asset base and meeting strict impoverishment levels. There are also adverse gift tax consequences that must be considered before depleting your assets. The key is to determine if you are able to finance a long-term care expense without it having a severe impact on your family.

If you decide that you would like to insure this risk with a LTC policy, you should make sure it has the features you need and is issued by a solid reputable company. There are currently a number of insurance companies that offer LTC insurance policies. Some are individual policies, while others are group policies obtained through professional associations or large employers. As with disability insurance, the major difference is that group policies are generally not "guaranteed renewable." This means the insurance company can change the premium, the benefits, or even cancel the master group policy.

Benefits vary from policy to

policy, but there are generally three recognized levels of care that will be identified for possible coverage. Skilled Care provides daily nursing and rehabilitation under the supervision of skilled medical personnel like registered nurses; Intermediate Care is similar but coverage is only approved for intermittent or occasional nursing and rehabilitative care; and Custodial Care provides help in daily activities by persons that do not need to be medically skilled. You also may be able to add a variety of riders, such as inflation protection, guaranteed insurability and renewability and waiver of premium.

The potential need for long-term care is a genuine risk. It is important to examine LTC insurance to see if it makes sense in your overall financial plan; however, you will find that there is no perfect policy. Many policy features must be compared. Obviously, the more benefits that are included, the higher the premium will be. □

*The author welcomes readers' questions. He can be reached at 1-800-262-3863.*

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# Munchausen syndrome by proxy: A different kind of child abuse

Mary M. Von Burg, M.S.  
Roberta A. Hibbard, M.D.  
Indianapolis

Munchausen syndrome by proxy (MSBP) is a malignant disorder of parenting described by Dr. Roy Meadow in 1977<sup>1</sup> to diagnose a serious form of child abuse in which the parent or caretaker relates what are later found to be fictitious illnesses in the child. These illnesses may be fabricated or induced. It can be very difficult to diagnose and is often overlooked for weeks, months or years. It is most often suspected through elimination or exclusion of other diagnoses and a bizarre pattern of illness that does not make clinical sense. Attention, sympathy and support for the parent may perpetuate the problem.

MSBP leads to extensive medical evaluations, procedures and hospitalizations for the child with significant short- and long-term consequences. Serious complications and death can result.<sup>2</sup> MSBP is a form of severe child abuse that must be reported to Child Protection Service (CPS). It usually includes<sup>3</sup>:

- An illness in a child that is fabricated and/or produced by a parent or caretaker.
- A parent or parent figure presenting the child for

## Abstract

Munchausen syndrome by proxy (MSBP) continues to mystify health care professionals, law enforcement officials and the judicial system. Even though the first cases were described in 1977, it remains puzzling why a parent would want to induce fictitious symptoms and illnesses in a child. Many professionals do not consider MSBP as a diagnosis because the parent, usually the mother, is so convincing that she is a "good" mother, cares about and wants the best for her child. This article is offered to further educate physicians that MSBP exists, can present in the form of *anything* and should be considered as a diagnosis in cases that do not make medical sense. Case examples are provided, along with common and not so common presentations. MSBP is a form of severe child abuse that must be reported to Child Protection Service when a child is endangered. Physicians play a critical role in identifying these children and recommending the best course of action to the rest of the system.

medical care persistently, often resulting in multiple medical procedures.

- Denial of the knowledge by the perpetrator as to the etiology of the illness
- Signs and symptoms for which a reasonable medical explanation cannot be determined.
- Acute "symptoms" that abate when the child is separated from the parent/caretaker.

As more is learned about this unusual and bizarre syndrome, more and more patterns and variability are identified. It can be anything and can affect any pediatric age group.<sup>4,11</sup> The most common age group is newborn to 8 years of age, and preverbal

children are at the highest risk.

## Case report

B.B. is an almost 3-year-old white boy who arrived at the emergency department via paramedics after they received a call that the child had a weak pulse and required cardiopulmonary resuscitation (CPR) by the mother. Upon their arrival, the child was sitting up, alert and in no distress. He was transported because of the history.

The child's history was remarkable for 27 emergency visits in the past 31 months of life and three hospitalizations in the previous seven months. He suffered two drug ingestions. One ingestion involved possible

mislabeling of a Tegretol bottle; however, the bottle was never shown to anyone despite the fact that it was reportedly brought to the hospital. He was diagnosed with unusual seizures, but no one other than his mother ever observed them. He had repeated extensive neurologic work-ups, and the electroencephalograms were all normal. The history of seizures was inconsistent with the observation of others – an awake, alert, playing child who had minutes before allegedly suffered a 15-minute major motor seizure. There had been increasing severity in presentation, from choking, to seizures, to a weak pulse requiring CPR by the mother. The physical examinations and extensive laboratory information had been within normal limits.

The family history revealed that B.B. had three siblings, each with an extensive medical history. His oldest sibling, age 9 years, had 13 hospitalizations and 19 emergency room visits, many of which were for vague complaints that were not supported by physical or laboratory examinations. He had suffered four drug ingestions (iron, aspirin, Dimetapp, and Dilantin). This child was diagnosed with having unusual seizures with a normal neurologic work-up; the seizures were observed only by his mother.

B.B.'s second sibling was a female who died at 11 months of age. She had no medical records from two weeks to 10 months of life, but at 10 months was presented with a history of apnea since birth. The mother was the only one who observed apnea. When she suffered her fatal cardiopulmonary arrest, retinal hemorrhages were noted. Her death was attributed to sudden

infant death syndrome (SIDS).

B.B.'s youngest sibling died at 4 1/2 months of age after four hospitalizations and four emergency department visits. This child's history of frequency and severity of apnea episodes was not confirmed upon hospitalizations. His medical work-up revealed only mild gastroesophageal reflux, treated with Reglan. He had no apnea or bradycardia spells documented on his extensive hospitalizations. No autopsy was done at the time of his death. His death was also ascribed to SIDS.

At the time of his presentation to the emergency department, B.B. was recognized by the nurse as a frequent user of emergency services. His entire physical examination at that time was within normal limits. It was then that the health care providers became concerned that B.B. may be a victim of MSBP. A welfare report regarding suspected child abuse was filed. The child subsequently was removed from the home and placed in foster care. The extensive medical history was uncovered at this time. In foster care, this child was observed to be a perfectly normal growing and developing child, with no seizures, unusual illnesses or episodes of choking or apnea.

#### **When to suspect MSBP**

The initial clinical presentation of MSBP is highly variable. The clues to diagnosis emerge when the illness "does not make sense," an extensive medical work-up does not identify a diagnosis to explain the symptoms adequately, or symptoms continue to change or escalate by report despite appropriate treatment. Children may present with extensive medical histories, numerous consultations,

tests, procedures and hospitalizations for which no real answers or resolutions evolve. Detailed observation usually results in recognition of significant secondary gains for the parent reporting the illnesses. Further evaluation often reveals the illnesses are observed by or occur only in the presence of one individual.

Some of the most commonly fabricated illnesses<sup>3</sup> include bleeding, seizures, central nervous system depression and apnea (Table).

Cystic fibrosis, renal stones, bacteremia and dehydration have also been fabricated, mimicked or induced by alteration of lab samples, manipulation of intravenous lines and poisoning. Ipecac induced vomiting<sup>12</sup> and laxative induced diarrhea<sup>13</sup> are examples of MSBP when the parent causes the symptoms by poisoning and denies knowledge of what might be the problem. Prolonged, really unusual, repeated and unexplainable conditions should be suspect. This does not mean that every unusual or unexplainable condition is MSBP. Thorough evaluation and observation will differentiate the factitious from the truly unusual or rare medical conditions.

While specific illnesses may be fabricated or induced in a child, real illnesses also occur. Children with special needs and chronic medical problems are particularly difficult to identify because of their real medical problems. It often is difficult to sort out the real illness from serious exaggerations and/or illnesses induced.

#### **Family features**

Common family characteristics are frequently but not always present. Mothers are usually the perpetra-



tors and appear very close and attentive to the child with an apparent need to control the child's environment. They are frequently likable and believable and make friends among hospital families and staff.

They may be depressed and may have unstable relationships and many needs for personal and social support. Medical sophistication is also common – the mother having more than average medical knowledge through previous formal training in a medical field or exposure to hospitals and medical issues via a sick relative, reading or fantasized career. In contrast, fathers are frequently distant, uninvolved or non-existent in the family structure. They will almost always support the mother's story but do not observe the onset of problems themselves. In some instances, however, fathers may not be aware of what history is being told by the mother, and they can confirm the illnesses related did not occur.

The psychiatric diagnosis of MSBP or factitious disorder by proxy cannot be made unless there is a medical diagnosis of a factitious disorder in the child. The perpetrator may have Munchausen syndrome, though often does not; rarely is there a psychosis. The psychiatric evaluator must be experienced and knowledgeable in this syndrome to offer appropriate guidance for evaluation and treatment of the child and perpetrator.

#### Treatment/management

Once MSBP is recognized as a serious possibility, immediate resolution of the medical dilemma should be sought, as well as a long-term plan for the well-being of the child.<sup>14</sup> All unnecessary tests or treatments should be discontin-

Table

### Munchausen syndrome by proxy: Common and not so common presentations

#### COMMON

- |   |   |
|---|---|
| 1. Bleeding<br>(blood in diapers,<br>throat, urine) | <ul style="list-style-type: none"> <li>- Warfarin poisoning</li> <li>- Phenolphthalein poisoning</li> <li>- application of exogenous blood to diapers or laboratory specimens (i.e., mother's blood into child's urine specimen)</li> <li>- addition of other substances, such as cocoa, paint or dyes</li> </ul> |
| 2. Seizures   | <ul style="list-style-type: none"> <li>- lying</li> <li>- poisoning (i.e., phenothiazine, hydrocarbons, salt, imipramine)</li> <li>- suffocation (i.e., carotid sinus pressure)</li> </ul>  |
| 3. Central nervous<br>system depression             | <ul style="list-style-type: none"> <li>- drugs (i.e., Lomotil, insulin, chloral hydrate, barbiturates, aspirin, diphenhydramine, tricyclic antidepressants, acetaminophen, hydrocarbons)</li> <li>- suffocation</li> </ul>  |
| 4. Apnea  | <ul style="list-style-type: none"> <li>- manual suffocation</li> <li>- poisoning (i.e., imipramine, hydrocarbon)</li> </ul>   |
| 5. Diarrhea   | <ul style="list-style-type: none"> <li>- lying</li> <li>- Phenolphthalein/other laxatives</li> <li>- lying</li> <li>- salt poisoning</li> </ul>   |
| 6. Vomiting   | <ul style="list-style-type: none"> <li>- Emetic poisoning (syrup of ipecac)</li> <li>- lying, sample presented not vomitus</li> <li>- induced manually</li> </ul>   |
| 7. Fever  | <ul style="list-style-type: none"> <li>- falsifying temperature</li> <li>- falsifying chart</li> <li>- injections of contaminated material into child's veins</li> </ul>  |
| 8. Rash   | <ul style="list-style-type: none"> <li>- drug poisoning</li> <li>- scratching or rubbing the skin</li> <li>- caustics applied to the skin</li> <li>- painting skin</li> </ul>   |
| 9. Bacteremia                                       | <ul style="list-style-type: none"> <li>- addition of contaminants to the blood (i.e., injecting fecal material into the child's IV line)</li> </ul>   |

#### NOT SO COMMON:

- |                             |   |
|-----------------------------|---|
| 1. Failure-to-thrive        | <ul style="list-style-type: none"> <li>- bulimic mothers may use ipecac to cause child to fit their ideal of thinness</li> <li>- withholding food</li> <li>- if child is in hospital, the parent can interfere with treatment and even suck back stomach contents through nasogastric tube</li> </ul> |
| 2. Unable to walk           | <ul style="list-style-type: none"> <li>- lying, forcing child to use wheelchair</li> </ul>  |
| 3. Hearing impairment       | <ul style="list-style-type: none"> <li>- lying</li> </ul>   |
| 4. Hypertension             | <ul style="list-style-type: none"> <li>- altering blood pressure chart</li> </ul>   |
| 5. Renal stone              | <ul style="list-style-type: none"> <li>- drug poisoning</li> <li>- addition of stone to child's urine to which blood has previously been added</li> </ul>   |
| 6. Cystic fibrosis          | <ul style="list-style-type: none"> <li>- lying</li> <li>- submitting false samples</li> </ul>   |
| 7. Developmental disability | <ul style="list-style-type: none"> <li>- lying</li> <li>- exaggerating</li> </ul>   |



ued immediately. A member of the medical team must be designated to pursue the interests of the child through coordinating appropriate evaluations and reporting of child abuse, as well as education of the social and legal professionals who may deal with the family.

Parents should not be told of suspicions until CPS has a chance to investigate. Maintaining strict confidentiality and limiting information flow internally are necessary to avoid making parents aware of concerns before the evaluation is complete. It may be prudent to restrict the hospitalized patient to the ward unless a staff member is present. This will minimize opportunities for a perpetrator to induce or fabricate a problem that cannot be corroborated.

In most cases, separating the parents from the child ("take a few days off from visiting") can be very helpful in assessing symptoms in the parents' absence. Before the parents are informed of the concerns, separation must be voluntary, but after CPS is involved, the separation may be ordered.

Nurses and physicians should carefully and completely document objective observations of the parent and child interactions, parent and staff interactions and the details surrounding illnesses or "episodes" of a problem (who observed, what happened, child's actual condition). This form of observation and documentation often identifies inconsistencies and exaggerations, such as the child who reportedly just had a grand mal seizure but is sitting up playing in bed when the nurse arrives.

Collection and handling of possible physical evidence (intravenous tubing, contaminated baby

bottles, tampered patient samples) should be carefully planned with the appropriate legal authorities and should include both CPS and law enforcement. Social and legal authorities can identify previous reports of concerns about the child, assist in the investigation and evidentiary collection and participate in making the best plan for protection of the child.

Psychiatric evaluation of the mother and child, as well as other family members, assists in identifying underlying pathology, secondary gains and strengths and weaknesses within the family.

The medical records of the child and other family members should be reviewed to determine the extent of the problem<sup>9</sup> and are usually necessary in the child to make the diagnosis. Careful consideration of the medical conditions and the numbers of hospitals and hospitalizations, doctors and doctor visits and phone calls to health care and ancillary providers should be documented. Discrepancies in stories and observations and unusual or persistent complaints unresponsive to treatment should be noted. Particularly worrisome is an escalation in the seriousness of complaints and interventions without success in treatment. These children seem most at risk for specific inflicted serious injury.

#### **Ongoing care**

Physicians will be asked and must be prepared to make recommendations to CPS regarding the child's care. If the child is not safe and his life is in danger, it must be stated. When the child's life is in immediate danger, the potential harm to the child must be emphasized. This does not always mean the child must be removed from parental care, but that is usually

prudent. Plans for ongoing monitoring of the child's health, usually by one provider, must be arranged. Any needs for psychiatric evaluation and treatment for the family or child should be outlined. Recommendations regarding school services and developmental intervention of other ancillary services should be considered.

CPS will look to physicians for guidance in handling these cases. Tell CPS what you think. While statutes don't always allow CPS to do what physicians think is best, we must do our best to educate and inform the investigating agencies to better protect children.

#### **Morbidity**

Morbidity and mortality of Munchausen syndrome by proxy are significant. In approximately 25% of cases, the illnesses are simulated only; in 50% of cases, the illnesses are produced; and in 25% of cases, the illnesses are both simulated and produced. One hundred percent of victims experience short-term morbidity in the form of painful tests or medical procedures, hospitalizations, harmful side effects from treatments, prolonged school absences or genuine disease that has been induced. Permanent disfigurement or impairment is reported in approximately 8% of victims and includes surgical scars, psychiatric impairment and central nervous system changes. Some children become "chronic invalids," and others eventually develop Munchausen syndrome.

Death is not uncommon. Ten percent of victims die from this problem, predominantly children less than 3 years of age. The sibling death rate is also high; when more than one child in the family is a victim of MSBP, the mortality rate is 30%. The most common causes

of death are suffocation, poisoning and infection."

### Case re-evaluation

Hindsight in many of these cases is 20/20. This condition is missed primarily because it is not included in the differential diagnosis – providers simply do not think about it. When it is considered, we struggle with serious questions about how it could even be possible. It is easier to accept an "unusual" problem than it is to question its truthfulness.

This family was not identified for many years because of some typical features of these families – doctor shopping, hospital hopping and medical conditions we don't always expect to see ourselves. The situation was probably accepted as "overanxious parent," and attention to the detail and serious escalation of the reported problems was minimal. It must not be forgotten that the mother was very convincing.

After an astute emergency nurse, who had read about this syndrome, recognized this child as a frequent emergency department patient, the ball started rolling. It took considerable diligence on the part of the care providers, CPS and consultants to put the entire

picture together by gathering and reviewing in detail all the medical records. Once we saw the forest, we recognized the trees.

The best suggestion to clinicians is to approach the bizarre, frequent or repeatedly unresponsive to therapy situation with great objectivity, attention to detail and an ounce of skepticism. Look for the forest. □

*Ms. Von Burg is administrative coordinator and Dr. Hibbard is associate professor of pediatrics and director of the IU Community Child Abuse Projects at the Indiana University Medical Center in Indianapolis.*

*Correspondence: Mary M. Von Burg, M.S., Administrative Coordinator, Community Child Abuse Projects, 1001 W. 10th, BU 444, Indianapolis, IN 46202.*

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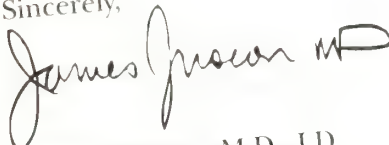
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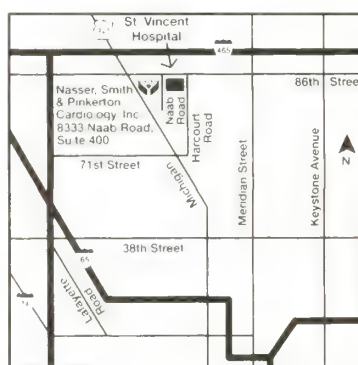


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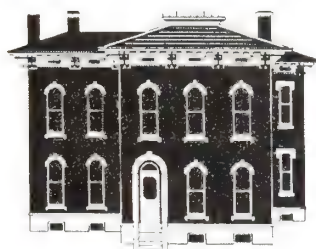
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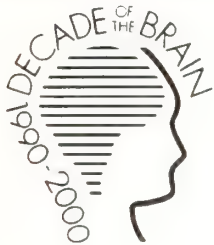
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## ■ alliance report

**Valerie Gates  
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The Indiana delegation to the AMA Alliance annual convention, held June 18 through 20 in Chicago, included Sylvia Dulay, Fran Foster, Valerie Gates, Cheryl Haslitt, Rosanna Iler, Patty Lackey and Janice Leiphart. Ann Wrenn, a national officer from Bloomington, also sat with our delegation when possible. Shirley Becker attended the legislation sessions to collect ideas for a legislative workshop.

The delegates participated in AMA-ERF, health promotion, legislative affairs and membership development programs June 18. They attended reference committees on health issues, organizational affairs, strategic plans and bylaws and voted on the recommendations from these committees after caucusing early Tuesday morning. We were proud to vote for Ann Wrenn as AMA Alliance secretary.

Robert McAfee, M.D., AMA president, and Percy Wootton, M.D., AMA-ERF president, addressed the delegates. Carol Phillips of Wisconsin will be Indiana's Alliance field director next year. Membership contact will be Mary Ann Nirschl from Virginia; legislation contact will be

Sara Rich from Ohio; health promotion contact will be Patti Herlihy from South Dakota; and AMA-ERF contact will be Donna Gosney from Alabama.

The Indiana delegation returned with many ideas to share with our county organizations for S.A.V.E. (Stop America's Violence Everywhere), scheduled Oct. 11. Ideas also were presented for membership, health projects and Doctor's Day.

John Knoté, M.D., a Lafayette radiologist and newly elected AMA vice speaker, spent time at an ISMA Alliance delegation meeting Sunday evening. In return, the Indiana alliance delegation enjoyed the "Race, Rattle and Roll" party held in Dr. Knoté's honor.

Vanderburgh County won an AMA-ERF award that was presented before the state oral report given by Valerie Gates. □



Delegates to the AMA Alliance annual convention held in June included: (front row from left) Patty Lackey, Evansville; Valerie Gates, Valparaiso; and Cheryl Haslitt, Muncie; (second row from left) Fran Foster, Fort Wayne; Rosanna Iler, Indianapolis; Ann Wrenn, Bloomington; Janice Leiphart, Muncie; and Sylvia Dulay, Evansville.

# Physicians Capital Source

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# isma leadership

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## TRUSTEES (Terms end in October)

### District

- 1 – Barney R. Maynard, Evansville (1995)
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- 4 – Arthur C. Jay, Lawrenceburg (1995)
- 5 – Fred E. Haggerty, Greencastle (1996)
- 6 – Ray A. Haas, Greenfield (1997)
- 7 – Ron Stegemoller, Danville (1995)
- 7 – John M. Records, Franklin (1996)
- 7 – Bernard J. Emkes, Indianapolis (1997)
- 8 – John V. Osborne, Muncie (1996)
- 9 – Stephen D. Tharp, Frankfort (1997)
- 10 – Thomas A. Brubaker, Munster (1995)
- 11 – Laurence K. Musselman, Marion (1996)

12 – Joseph R. Manthey, Bluffton (1997)

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MSS – Mike Hardacre, Noblesville (1995)

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(Terms end in October)

### District

- 1 – Bruce W. Romick, Evansville (1997)
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- 7 – Frank Johnson, Indianapolis (1995)
- 7 – Paula A. Hall, Mooresville (1997)
- 7 – Girdhar Ahuja, Indianapolis (1996)
- 8 – Susan K. Pyle, Union City (1997)
- 9 – Daniel Berner, Lafayette (1995)
- 10 – John L. Swarner, Valparaiso (1997)
- 11 – Regino B. Urgena, Marion (1995)
- 12 – Scott Wagner, Fort Wayne (1995)
- 13 – Richard J. Houck, Michigan City (1997)
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 Marvin E. Priddy, Fort Wayne (1995)  
 Michael O. Mellinger, LaGrange (1995)  
 John A. Knote, Lafayette (1996)  
 Shirley Khalouf, Marion (1996)  
 William Beeson, Indianapolis (1996)

## AMA ALTERNATE DELEGATES

(Terms end Dec. 31)

Barney Maynard, Evansville (1995)  
 George Rawls, Indianapolis (1995)  
 Paula Hall, Mooresville (1995)  
 Max N. Hoffman, Covington (1996)  
 C. Dyke Egnatz, Schererville (1996)  
 Alfred Cox, South Bend (1996)

## DISTRICT OFFICERS & MEETINGS

- 1 - Pres: John Berry, Evansville  
 Secy: William Penland, Evansville  
 Annual Meeting: May 16, 1996
- 2 - Pres: Merlin Coulter, Washington  
 Secy: R.M.C. Harrison, Washington  
 Annual Meeting: May 9, 1996
- 3 - Pres: Robert Arnold, Salem  
 Secy: Kalen Carty-Kemker, Salem  
 Annual Meeting: May 15, 1996
- 4 - Pres: Leon Michl, Madison  
 Secy: Howard Jackson, Madison  
 Annual Meeting: May 1, 1996
- 5 - Pres: Ranganath Vedala, Brazil  
 Secy: Rahim Farid, Brazil  
 Annual Meeting: May 30, 1996
- 6 - Pres: Ray Haas, Greenfield  
 Secy: Douglas Morrell, Rushville  
 Annual Meeting: May 8, 1996
- 7 - Pres: Russell Judd, Indianapolis  
 Secy: John Schneider, Indianapolis  
 Annual Meeting: to be announced
- 8 - Pres: to be named

Secy: to be named

- Annual Meeting: June 5, 1996
- 9 - Pres: to be named  
 Secy: Stephen D. Tharp, Frankfort  
 Annual Meeting: June 12, 1996
- 10 - Pres: Frank Hieber, Munster  
 Secy: Floyd Manley, Hammond  
 Annual Meeting: to be announced
- 11 - Pres: Agnes Kenny, Peru  
 Secy: Jack Higgins, Kokomo  
 Annual Meeting: Sept. 13, 1995
- 12 - Pres: Joseph Manthey, Liberty Center  
 Secy: David Haines, Warsaw  
 Annual Meeting: Sept. 14, 1995
- 13 - Pres: Mohammad Arab, LaPorte  
 Secy: Donald Smith, South Bend  
 Annual Meeting: to be announced

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# Uncertain Times: Preventing Illness, Promoting Wellness

**1996 International  
Conference on  
Physician Health**

**February 8-10  
Chandler, Arizona**

Authors are invited to submit abstracts for consideration as part of the 1996 International Conference on Physician Health, which is sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, and the Federation of Licensing Authorities of Canada.

Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are:

- Coping with changing economic or practice circumstances
- Stress and physician health
- Epidemiologic data
- The effects of violence directed at physicians
- Violence occurring within physicians' families
- Patient exploitation
- Mental illness, including substance abuse
- Physical illness and disability
- Special populations
- Comparative data across states or countries
- Physician well-being and family functioning
- Updates on clinical areas (depression, pharmacotherapy, etc.)

Three types of presentations are welcome:

- Poster presentations: written presentations of data-based research
- Paper sessions: Oral presentations of scientific, data-based findings on issues of physician health. Paper presentations will be grouped into related panels, with individual papers presented in 20 minute time slots
- Workshops: Training or instructional presentations designed to improve the skills and knowledge of persons working in the physician health field

Abstracts for all presentations must be submitted on the abstract submission form which is available from: American Medical Association, Physician Health Program, Attn. E. Tejcek, 515 North State Street, Chicago, IL 60610.

All presenters must register for the conference and will pay the AMA member rate. Presenters will be responsible for their own expenses.

**Deadline for  
submission is  
October 2, 1995**

Questions or requests for abstract submission forms may be sent to the address above or directed to 312 464-5066 or faxed to 312 464-5841.

**American Medical Association**

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# ■ cme calendar

## St. Mary's Medical Center

St. Mary's Medical Center in Evansville will present the Annual Family Medicine Seminar Oct. 12 in the medical center's amphitheatre.

The seminar will discuss stroke recognition and intervention. For more information, call (812) 479-4468.

## Reid Hospital

Reid Hospital and Health Care Services in Richmond will sponsor a Heart Failure Mini-Seminar Nov. 2.

To register, call Marie Hopper at (317) 983-3112.

## Indiana University

The Indiana University School of Medicine will present the following CME courses:

- Sept. 22-23**— 18th Annual Midwest Glaucoma Society Meeting – Glaucoma: Making Good Decisions.
- Sept. 29-30**— Management of Low Back Pain for the Primary Care Physician, Holiday Inn Crowne Plaza (Union Station), Indianapolis.
- Oct. 24** – Obsessive Compulsive Disorder Teleconference, multiple sites to be announced.
- Oct. 25** – Update on the Management of HIV Infection.
- Nov. 3** – Breast Cancer 1995, Clinical Controversies and Management.
- Nov. 9** – 19th Annual Garceau-Wray Lectureship.
- Nov. 11** – Fifth Annual

Trauma/Surgical Critical Care Symposium.

- Nov. 17** – American Academy of Physicians Indiana Scientific Meeting, Hyatt Regency, Indianapolis.
- Dec. 1-2** – The Challenges of Hemostasis in Cardiothoracic Surgery.

All courses will be held at the University Place Conference Center and Hotel in Indianapolis, unless otherwise noted. For more information, call (317) 274-8353.

## St. Vincent Hospitals

St. Vincent Hospital and Health Services in Indianapolis will present these CME courses:

- Sept. 28- Oct. 1** – Ninth International Congress on Ultrasound Examination of the Breast, site to be announced, Indianapolis.
- Oct. 13** – Richter Lectureship, St. Vincent Marten House Hotel and Conference Center, Indianapolis.
- Oct. 27** – Neurology for Primary Care - 1995, St. Vincent Marten House Hotel and Conference Center, Indianapolis.
- Nov. 3** – Emergency Room Physicians Seminar, The Ritz Charles, Indianapolis

For more information, call Beth Hartauer, (317) 338-3460.

## Community Hospitals Indpls.

Community Hospitals Indianapolis will sponsor the Sixth Annual Cardiovascular Symposium: Management Strategies for Primary

Care Practitioners Sept. 30 at the Indianapolis Convention Center.

The symposium will run from 8 a.m. to 3:30 p.m. For details, call Donna Grahm at (317) 355-5714.

## University of Cincinnati

The University of Cincinnati Medical Center will present "Contemporary Management of Common Respiratory Problems" Oct. 13 and 14 at the university's medical center.

The program is designed for primary care physicians and coincides with Cincinnati's Tall Stacks celebration. For information, call Robbie Cornelison, (513) 558-5391.

## University of Wisconsin

The University of Wisconsin Medical School will sponsor the Infectious Disease Update - 1995 at the Holiday Inn - West in Madison, Wis.

All physicians and other allied health professionals managing infectious disease patients are invited to attend. For details, call Sarah Aslakson, (608) 263-2856.

## University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Sept. 18-19**— Update on Pulmonary and Critical Care Medicine.
- Sept. 27-28**— Office Procedures for Primary Care Physicians Seventh Annual Workshop Course.
- Oct. 19-21** – Seventh Annual Modern Perinatal Problems.

All courses will be held at The Towsley Center, University of Michigan, in Ann Arbor unless otherwise listed. To register, call Vivian Woods at (313) 763-1400. □



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- Krieg, DeVault, Alexander & Capehart

ISMA members are not charged for the initial phone calls to the ISMA or the consultants.



## ■ news briefs

### Symposium to honor retiring medical school dean

Walter J. Daly, M.D., retiring dean of the Indiana University School of Medicine, will be honored at a scientific symposium Tuesday, Oct. 31, at the IUPUI Conference Center in Indianapolis.

The following former IU chief residents, appointed by Dr. Daly, who have continued in academic medicine will present papers from 1 p.m. to 3 p.m. in the order listed:

- David W. Crabb, M.D., professor of medicine and biochemistry and molecular biology, IU School of Medicine, "Genetics of Alcohol Metabolism and Alcoholism."

- Jon P. Lindemann, M.D., professor of medicine, Division of Cardiology, University of Arkansas for Medical Sciences, Little Rock, Ark., "Alpha-Adrenergic Regulation of Cardiac Function."

- Friedrich Luft, M.D., director, nephrology, hypertension and genetics, Franz-Volhard Klinik, Berlin, "Autosomal Dominant Hypertension and Brachydactyly, Adventures at 12q13."

- Frank Vinicor, M.D., director of diabetes translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, "Is Diabetes a Public Health Problem?"

- August M. Watanabe, M.D., vice president of Eli Lilly and Co., president of Lilly Research Laboratories, Indianapolis; professor of medicine and pharmacology and toxicology, IU School of Medicine, "The Revolution in Biomedical Discovery Research."

The following presentations will highlight the research programs that have flourished under Dr. Daly's deanship. They will be presented in the order shown from

3:30 p.m. to 5 p.m.

- Ting-Kai Li, M.D., associate dean for research, distinguished professor of medicine and of biochemistry and molecular biology, IU School of Medicine; adjunct professor of nursing, IU School of Nursing, "Research Progress - 1983-1995."

- Hal E. Broxmeyer, Ph.D., scientific director, Walther Oncology Center; Mary Margaret Walther professor of medicine and professor of microbiology and immunology, IU School of Medicine, "Cord Blood as an Alternative Source of Transplantable Hematopoietic Stem and Progenitor Cells."

- C. Conrad Johnston Jr., M.D., professor of medicine, IU School of Medicine; adjunct professor of nursing, IU School of Nursing; "Osteoporosis: A Growing Epidemic."

- David A. Williams, M.D., associate professor and Freida and Albrecht Kipp Distinguished Investigator in Pediatrics and associate professor of medical and molecular genetics, IU School of Medicine, "New Therapies for Genetic Diseases Affecting Children."

- Douglas P. Zipes, M.D., distinguished professor of medicine and professor of pharmacology and toxicology, IU School of Medicine, "Experience with Arrhythmias at IU."

Anyone interested may attend.

### Seminar on grief open to physicians, nurses

"The Grief Experience: A Toolkit for Helping Professionals" is the title of an upcoming seminar designed to help physicians, nurses, social workers, funeral directors and chaplains.

The program will be from 7:30

a.m. to 4:15 p.m. Wednesday, Nov. 29, at the Holiday Inn North in Indianapolis.

Dr. Alan Wolfelt, director of the center for loss and life transition in Fort Collins, Colo., is the keynote speaker.

Indiana Oncology Social Work and the Indiana Funeral Directors are presenting the program, assisted by the Little Red Door Cancer Agency and the American Cancer Society, Indiana Division.

Sponsors are checking to see if CME credit will be available.

For more information, contact the Little Red Door Cancer Agency, 1801 N. Meridian St., Indianapolis, IN 46204, (317) 925-5595.

### Epidemiology newsletter offered free to physicians

*The Indiana Epidemiology Newsletter*, published monthly by the Indiana State Department of Health, is available free of charge to all Indiana physicians. The newsletter provides current information on public health and epidemiologic trends of interest to health professionals.

Physicians serving on local boards of health are encouraged to obtain this publication.

Call (317) 383-6412 to receive a free subscription.

### Magazine lists IUMC among best hospitals

Indiana University Medical Center (IUMC) in Indianapolis has been ranked among the top hospitals nationally in five specialty areas listed by *U.S. News & World Report* in the magazine's 1995 *America's Best Hospitals Guide*.

The 40 highest-scoring hospitals in particular specialty areas are listed. The hospitals chosen are affiliated with 127 academic

## ■ news briefs

medical centers nationally. The IUMC is noted for excellence in clinical programs for cancer, ranked 16th; gastroenterology, 17th; orthopaedics, 38th; urology, 14th; and otolaryngology, 27th.

The magazine relied on a mathematical model to determine objective rankings for each specialty area as well as reputational scores.

### **New Alzheimer's drug being studied at IUMC**

As part of the largest-ever global clinical trial, the Indiana University Medical Center is investigating a new medicine to treat the symptoms of Alzheimer's disease. The Center for Alzheimer's Disease and Related Disorders is participating in the drug study of ADENA.

About 40 patients with probable mild-to-moderate Alzheimer's disease will take part in the trial.

The IUMC Alzheimer program is one of 28 centers nationally that

receive core grant funding from the National Institutes of Health.

### **Nominees wanted for 'Country Doctor' award**

Nominations are being accepted for "The Country Doctor of the Year Award."

The award, given to the rural physician who best exemplifies the spirit, skill and dedication of America's country doctors, is co-presented by Staff Care, an Irving, Tex.-based interim physician staffing service, and the Country Doctor Museum in Bailey, N.C.

The nominated physician must practice in a community of 20,000 people or fewer, have a record of at least three years of continuous service in the community, provide a high quality of care and show extraordinary dedication to his or her patients.

The winner will receive an interim physician for one week, a service valued at about \$10,000.

Nomination forms, due Sept.

30, 1995, may be ordered by calling Staff Care, 1-800-685-2272.

### **Play to focus on scientific researcher**

"Koch," a play about the discoverer of the etiological agents of tuberculosis, cholera and anthrax, will be presented at 7:30 p.m. Sept. 29 and 30 at North Central High School in Indianapolis.

Written by Elmer W. Koneman, M.D., the play focuses on Robert Koch and his scientific achievements, his personality changes and conflicts with the government. At issue is how much time a person can devote to his work at the expense of his family and how much a negative personality, stubborn ego, self-interest and snubbing of friends and colleagues detracts from the fame a person achieves through academic efforts.

Tickets are \$10 and will be available at the door or by calling (317) 786-9663. □

## Look-alike and sound-alike drug names

	<b>MEVACOR</b>	<b>MIVACRON</b>
<b>Category:</b>	Antihyperlipidemic	Muscle relaxant
<b>Brand name:</b>	Mevacor, MSD	Mivacron, BW
<b>Generic name:</b>	Lovastatin	Mivacurium chloride
<b>Dosage forms:</b>	Tablets	Injection
	<b>SUMATRIPTAN</b>	<b>SOMATROPIN</b>
<b>Category:</b>	Migraine	Growth hormone
<b>Brand name:</b>	Imitrex, Cerenex	Humatrope, Lilly
<b>Generic name:</b>	Sumatriptan	Somatropin
<b>Dosage forms:</b>	Injection	Powder for injection

## ■ drug names

**Benjamin Teplitsky, R. Ph.  
Brooklyn, N.Y.**

**L**ook-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □



## ■ obituaries

### **Virgil E. Angel, M.D.**

Dr. Angel, 67, a Highland family physician, died July 21, 1995.

He was a 1958 graduate of the Indiana University School of Medicine and served in the U.S. Army.

Dr. Angel was a member of the American Academy of Family Physicians and was on the staff at The Community Hospital of Munster. He had served as chairman of the Lake County Board of Health.

### **Richard E. Buckingham, M.D.**

Dr. Buckingham, 81, a Bloomington general practitioner, died May 18, 1995, at Meadowood Health Center.

He was a 1942 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Buckingham practiced in Bloomington for 53 years.

### **Lee M. Cattell Jr., M.D.**

Dr. Cattell, 77, a retired orthopaedic surgeon in Indianapolis and Kokomo, died June 7, 1995, in Louisville, Ky.

He was a 1943 graduate of the University of Michigan Medical School and an Army veteran of the Korean War.

Dr. Cattell was affiliated with Meridian Orthopaedic Associates in Indianapolis, retiring in 1993. He served on the staffs of Community, Winona Memorial and Methodist hospitals. In Kokomo, he was in private practice and chief of surgery at St. Joseph Hospital and chief of staff at Howard Community Hospital. He also served as orthopaedic consultant to Grissom Air Force Base Hospital in Peru. Dr. Cattell was a

diplomate of the American Academy of Orthopaedic Surgeons.

### **John R. Crist, M.D.**

Dr. Crist, 70, a retired family practitioner in Mount Vernon, died May 21, 1995, at his home in Evansville.

He was a 1953 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Crist had served as a board member and director of medical services at Deaconess Hospital in Evansville.

### **Ramon A. Henderson, M.D.**

Dr. Henderson, 80, a retired Muncie pediatrician, died May 12, 1995, at Ball Memorial Hospital in Muncie.

He was a 1937 graduate of the Indiana University School of Medicine and served as a captain in the Army Medical Corps during World War II.

Dr. Henderson, who opened his practice in Muncie in 1940, was one of the founders of the Children's Clinic. He was a member of the American Academy of Pediatrics. He was named a Sagamore of the Wabash by Gov. Evan Bayh.

### **D. Stanley Houser, M.D.**

Dr. Houser, 89, a retired obstetrician-gynecologist who lived most of his life in North Liberty, died May 25, 1995.

He was a 1946 graduate of the Northwestern University Medical School.

Dr. Houser practiced in Lakeville and South Bend. He was a fellow of the American College of Obstetricians and Gynecologists.

### **Ralph U. Leser, M.D.**

Dr. Leser, 89, a retired Indianapolis internist, died May 28, 1995.

He was a 1930 graduate of the Indiana University School of Medicine, where he later served as an associate professor for 25 years. He was an Army Air Forces veteran of World War II.

Dr. Leser retired in 1981, after 51 years in private practice. He was house physician for the Indianapolis Symphony Orchestra 13 years. He was a fellow of the American College of Physicians.

### **Margaret T. Owen, M.D.**

Dr. Owen, 95, a retired Bloomington internist, died May 23, 1995, at Meadowood Retirement Center in Bloomington.

She was a 1926 graduate of the Indiana University School of Medicine.

Dr. Owen had a practice in Williamsport and Attica along with her husband, Abraham M. Owen, now deceased, and was a staff member at St. Elizabeth Hospital in Lafayette. She opened a practice in Bloomington in 1942. She was on the Bloomington Hospital staff and was president of the Monroe County Medical Society. After World War II, she and her husband had a joint practice until his death in 1959.

### **Harold G. Petitjean, M.D.**

Dr. Petitjean, 88, a retired family practitioner in Gibson County, died June 10, 1995, at Holiday Health Care.

He was a 1930 graduate of the Indiana University School of Medicine and served in the Army Air Corps.

Dr. Petitjean, a native of Posey



County, practiced in Warrenton and Haubstadt. He had honorary staff positions at Deaconess and Welborn hospitals and St. Mary's Medical Center. He received a commendation for outstanding service from Gov. Otis Bowen and the Brute Society Award from Bishop Gerald Gettlefinger for outstanding Christian stewardship.

**Thomas A. Redlin, M.D.**

Dr. Redlin, 64, a retired Elkhart anesthesiologist, died May 2, 1995, at his home.

He was a 1967 graduate of the Medical College of Wisconsin and a U.S. Air Force veteran.

Before moving to Elkhart, Dr. Redlin was affiliated with Illinois Masonic Hospital, University of Illinois Hospital, Presbyterian St. Luke's Medical Center and Community Hospital in Geneva, Ill. He was a faculty member at the Medical College of Wisconsin, Abraham Lincoln School of Medicine and Rush-Presbyterian St. Luke's Medical Center. He was a member of the American Society of Anesthesiologists.

**John A. Robb, M.D.**

Dr. Robb, 79, a retired Indianapolis radiologist, died May 31, 1995, at his home in Indianapolis.

He was a 1943 graduate of the University of Nebraska College of Medicine.

When Dr. Robb began his practice, the radiology training program at Wishard Hospital was on probation due to a lack of staff.

Dr. Robb and an associate volunteered to staff the department. He continued the voluntary support throughout his private practice from 1946 to 1972. When he closed his private practice in 1972, he joined the department of radiology at the Indiana University Medical Center full-time and became known as a skeletal expert. He was named outstanding teacher by radiology residents in 1975.

**Bernard D. Rosenak, M.D.**

Dr. Rosenak, 85, a retired Indianapolis gastroenterologist, died June 15, 1995. He was living in Phoenix at the time of his death.

He was a 1933 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Rosenak was a clinical professor of medicine at the IU School of Medicine until 1984 and retired as clinical professor emeritus. He served as chief of gastrointestinal service at IU Hospital and Wishard Memorial Hospital until 1974. He also was affiliated with Methodist, St. Vincent and veterans hospitals. He was a fellow of the American College of Physicians.

**Arthur N. Scudder, M.D.**

Dr. Scudder, 86, a retired Brownsburg family practitioner, died May 27, 1995.

He was a 1932 graduate of the Indiana University School of Medicine.

Dr. Scudder, who had a family practice in Brownsburg from 1933

to 1985, delivered 3,641 babies.

**Thomas C. Tyrrell, M.D.**

Dr. Tyrrell, 82, a Munster general surgeon, died June 27, 1995, in Naperville, Ill.

He was a 1937 graduate of the St. Louis University School of Medicine.

Dr. Tyrrell was the first Lake County board-certified member of the American College of Surgeons, a past president of the Lake County Medical Society and a lecturer at the surgery clinic at Loyola University in Chicago. He was past chief of staff at St. Margaret Hospital in Hammond and St. Margaret Mercy Healthcare Center. He was a former AMA delegate.

**James B. Warriner, M.D.**

Dr. Warriner, 78, a retired Indianapolis internist, died May 10, 1995.

He was a 1941 graduate of the Indiana University School of Medicine. During World War II, he was a medical officer with the 24th Infantry Division of the Army, responsible for field hospitals in Guam and the Philippines.

Dr. Warriner was in private practice from 1951 to 1981. He served on the planning committees for the original Community Hospital and remained on the medical staff there until his retirement in 1981. He was a member of the medical staff at St. Francis and University hospitals. □

**Dr. Henry Feuer** of Indianapolis Neurosurgical Group, was appointed to the National Football League Subcommittee on Concussions. He also spoke at a meeting on "Controversies in Decision Making: Neurological Sports Injuries" at the University of Miami School of Medicine; he presented a paper and was a panelist on the topic of acute management of the seriously injured athlete. He is the author of a chapter titled "History, Physical Examination and Acute Management of Spinal Injury" in the second edition of *The Lower Extremity and Spine in Sports Medicine*.

**Dr. William K. Nasser** of Nasser, Smith and Pinkerton Cardiology in Indianapolis received a 1995 Distinguished Alumni Award from the Indiana University School of Medicine. A 1961 graduate of IU, Dr. Nasser is a clinical professor of medicine at IU and is a member of the school's Medical Alumni Council and the Dean's Council for the School of Medicine.

**Dr. John P. Donohue** of Indianapolis received the 1995 Distinguished Faculty Award from the Indiana University School of Medicine. A graduate of Cornell University Medical College, he is distinguished professor and chairman of the department of urology at the IU Medical Center.

**Dr. John M. Records** of Franklin was named Family Physician of the Year by the Indiana Academy of Family Physicians. A 1961 graduate of the Indiana University School of Medicine, Dr. Records has been in solo practice since 1974.

**Dr. Jung I. Park**, a Munster otolaryngologist and plastic

surgeon, presented a paper on "Preoperative Facial Nerve Mapping in Face Lift" at the International Congress for Aesthetic Surgery in Paris, France.

**Dr. John C. Johnson**, director of ECP Healthcare in Valparaiso, was named a diplomate of the American Board of Medical Management, the national certifying agency for physician executives.

**Dr. Rick C. Sasso** of Indianapolis Neurosurgical Group co-authored a paper presented at the annual meeting of the Mid-America Orthopaedic Association in Palm Beach, Fla.; the title of the paper was "Postoperative Drains in Iliac Crest Bone Graft Donor Sites: A Prospective, Randomized Study." He also presented a clinical study on "Outpatient Lumbar Discectomy" at the annual

meeting of the Indiana Orthopaedic Society.

**Dr. P. Eva Fadul** of Indianapolis was one of 36 anesthesiologists from around the country chosen for the American Society of Anesthesiologists annual Leadership Spokesperson Training Program.

**Dr. John H. Abrams**, an Indianapolis ophthalmologist, spoke on sports-related ocular injuries at the Johnson and Johnson Sports Medicine Symposium during the National Athletic Trainers Association annual meeting in Indianapolis.

**Dr. Mary Walsh** of Northside Cardiology in Indianapolis spoke on "Hormones...For Better or For Worse" at the American Heart Association's Women and Wellness Conference.

**Dr. Eric Prystowsky** of

### Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

#### May 1995

Brown, Timothy N., Crawfordsville  
Cleary, Robert E., Indianapolis  
Cohon, Kathryn M. Cox, Granger  
Ferrara, Thomas A., Indianapolis  
Fondak, Alexander A., Kokomo  
Hershberger, Daryl, LaGrange  
Huber, Richard G., Bedford  
Huse, Patricia G., Indianapolis  
Loomis, Glenn A., Indianapolis  
Newell, Maximillian S., Indianapolis  
Roth, Bertram S., Indianapolis  
Schwartz, Alan L., Indianapolis  
Sentany, Marki S., Indianapolis  
Smith, Robert D., Lafayette  
Summers, Michael L., Greenfield

#### June 1995

Angel, Virgil E., Highland  
Barrett, Shari L., Evansville  
Camm, William B., Indianapolis  
Connerly, Patrick W., New Haven  
Fisch, Gary R., Indianapolis  
Hussey, Lawrence K., South Bend  
Larson, John R., Bremen  
Lee, Shuishih S., Fort Wayne  
Nowzaradan, Philip, Valparaiso  
Obando, Guillermo, Bedford  
Ogle, Mark R., Carmel  
Sanders, Melanie, Indianapolis  
Stanford, John R., Fort Wayne  
Stapp, Emily J., Jeffersonville  
Weeks, Michael B., Carmel  
Woodruff, Richard N., Richmond  
Wylie, Robert R., Bloomington □



Northside Cardiology in Indianapolis has co-authored a book titled *Cardiac Arrhythmias*, published by McGraw-Hill.

**Dr. Richard D. Zeph**, a Carmel facial plastic surgeon, was a speaker and instructor at the Fitz-Hugh Symposium – Fundamentals of Rhinoplasty meeting in Charlottesville, Va. He spoke on surgery of the osseocartilaginous vault (dorsal profile modification and osteotomies), osseocartilaginous vault surgery (advanced considerations) asymmetric nose and deviated nose. The meeting was co-sponsored by the American Academy of Facial Plastic and Reconstructive Surgery and the University of Virginia School of Medicine.

**Dr. William Beeson**, an Indianapolis facial plastic and reconstructive surgeon, was invited to Seoul, Korea, to lecture on laser surgery as a guest of Samsung University School of Medicine. He also has been appointed chairman of the standards and survey procedures committee for the Accreditation Association for Ambulatory Health Care.

**Dr. John D. Slack** of Nasser, Smith and Pinkerton Cardiology in Indianapolis has been certified by the American Board of Assurance and Utilization Review Physicians, an organization dedicated to education and the improvement of health care quality.

**Dr. Bruce H. Matt** of University Otolaryngology Associates in Indianapolis received the excellence in teaching award from the chief residents in otolaryngology-head and neck surgery at the Indiana University School of Medicine. He also has been promoted to associate professor of otolaryngology-head and neck

surgery at IU.

**Dr. Jeffery Pierson** of Hoosier Orthopaedics and Sports Medicine in Indianapolis spoke on total joint replacement at the Indiana Workman's Compensation Institute.

**Dr. Kathryn B. Einhaus**, a Fort Wayne obstetrician/gynecologist, was the speaker at Ivy Tech State College's commencement ceremony in Fort Wayne.

**Dr. Michael Mastrangelo**, a retired Fort Wayne surgeon, has joined the UNIMED Medical Advisory Board. UNIMED is a registered Preferred Provider Organization.

**Dr. Melvin H. Coffel**, a Vincennes otolaryngologist, has retired after more than 50 years in practice, 49 of them in Vincennes.

**Dr. Dana O. Troyer**, a retired Goshen ophthalmologist, was named Humanitarian of the Year by the Indiana Academy of Ophthalmology. He was honored for his years of work as a medical missionary in India, Ghana and Vietnam.

**Dr. Karen M. Wheeler** and **Dr. Mary R. Brunner**, both of Zionsville, were elected to fellowship in the American Academy of Pediatrics.

**Dr. John M. Brumfield** of Anderson has been certified by the American Board of Anesthesiology.

**Dr. Robert W. Gilmore**, a Michigan City pediatrician, has retired after 46 years in practice.

**Dr. Phillip N. Eskew Jr.** of Carmel received the Outstanding District Service Award from the American College of Obstetricians and Gynecologists.

**Dr. Jack P. Clark**, a Syracuse family physician, received the Torch Award from the National Association of the United Method-

ist Scouts and the General Board of Discipleship. The religious service award recognizes outstanding service to youth.

**Dr. Max E. Sneary**, an Avilla family physician, has retired, but will continue as medical director at Sacred Heart Home.

**Dr. James M. Kirtley** and **Dr. Jose Peralta** received Citizen of the Year Awards from the Crawfordsville/Montgomery County Chamber of Commerce. Dr. Kirtley, an obstetrician/gynecologist, served as a city councilman, a county commissioner and a state senator. Dr. Peralta, a surgeon, was recognized for being "the kind of Hoosier who has truly made significant difference to his family, his community and his profession." Dr. Peralta also was named a Sagamore of the Wabash at the time the award was presented.

**Dr. Maurice E. John**, a Jeffersonville ophthalmologist, was named Professional Person of the Year during the Southern Indiana Chamber of Commerce's annual Small Business Awards program.

**Dr. Robert Hanneman**, a pediatrician at Arnett Clinic in Lafayette, was elected vice president of the American Academy of Pediatrics.

**Dr. Bradley Black**, a New Albany ophthalmologist, participated in a new nationwide program called Mission Cataract USA. His group practice offered free eye screenings, and surgery if necessary, to financially eligible patients.

**Dr. Clarence W. Boone**, an obstetrician/gynecologist, was elected president of the medical staff of the Methodist Hospitals in Gary. **Dr. David L. Ashbach**, a nephrologist, is the president-elect.



## ■people

**Dr. Larry G. Cole**, a Yorktown family physician, has retired from his private practice but will continue as the company physician at Borg Warner Automotive.

### New ISMA members

**Rowena L. Archibald**, M.D., Indianapolis, occupational medicine.

**Ihor J. Bilyk**, M.D., Fort Wayne, neonatal-perinatal medicine.

**Richard M. Carr**, M.D., Indianapolis, otolaryngology.

**Jeffrey C. Cooke**, M.D., Indianapolis, vascular surgery.

**David G. Dewar**, M.D., Chesterfield, family practice.

**Curtis L. Gingrich**, M.D., Logansport, family practice.

**Stephen L. Hantman**, M.D., Evansville, internal medicine.

**Daniel L. Hartman**, M.D., Indianapolis, internal medicine.

**Fatima E. Jaffer**, M.D., Highland, internal medicine.

**John G. Jones**, M.D., New

Palestine, emergency medicine.

**Darryl L. Kaelin**, M.D., Indianapolis, physical medicine and rehabilitation.

**John R. Kim**, M.D., Fort Wayne, diagnostic radiology.

**Sheryl M. King**, M.D., Bloomington, pediatrics.

**Robert V. Klaasen**, M.D., Indianapolis, family practice.

**Drayton Logan**, M.D., Indianapolis, radiation oncology.

**Robert G. Manolakas**, M.D., Bloomington, physical medicine and rehabilitation.

**Douglas A. Mazurek**, M.D., Valparaiso, internal medicine.

**W. David Moore**, M.D., Marion, obstetrics and gynecology.

**James J. Mozzillo**, M.D., Indianapolis, family practice.

**Mark A. Muckway**, M.D., Evansville, neurology.

**Michael E. Parker**, M.D., Fort Wayne, diagnostic radiology.

**Roberto R. Patron**, M.D., Indianapolis, anesthesiology.

**Phillip A. Rettenmaier**, D.O.,

Fort Wayne, family practice.

**Karen D. Rodman**, M.D., Indianapolis, neurology.

**Peter I. Sallay**, M.D., Indianapolis, orthopaedic surgery.

**Robert N. Severinac**, M.D., Fort Wayne, plastic surgery.

**John M. Skantz**, M.D., Indianapolis, neurology.

**Richard P. Sloan**, M.D., Evansville, nephrology.

**Suzanne B. Smith-Elekes**, D.O., Fort Wayne, infectious diseases.

**Conrad J. Tirre**, M.D., Elkhart, plastic surgery, hand surgery.

**John R. Trost**, M.D., Evansville, general surgery.

**Eric N. Wegener**, M.D., Seymour, family practice.

**Jamie S. Weiner**, M.D., Indianapolis, internal medicine.

**Janet L. Wendeln**, M.D., Indianapolis, anesthesiology.

**Tamara B. Wyse**, M.D., Indianapolis, ophthalmology. □

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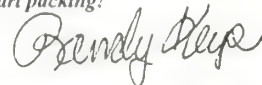
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**NOTRE DAME FANS** - Memorial Hospital, South Bend, Ind., is accepting applications for BE/BC IMs and FPs. OB optional, salaried position/production bonus, group call coverage, teaching hospital. Contact Vivian M. Luce, 1-800-765-3055, Cejka & Co., or fax CV for immediate attention, (314) 726-3009.

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<b>1,000</b>	<ul style="list-style-type: none"> <li>\$1,000 calendar year deductible, \$2,000 per family</li> <li>Stop-Loss limit \$5,000 per person, \$10,000 per family</li> </ul>	✓	✓	
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<b>5,000</b>	<ul style="list-style-type: none"> <li>\$5,000 calendar year deductible, \$15,000 per family</li> <li>Stop-Loss limit \$25,000 per person, \$50,000 per family</li> </ul>	✓	✓	

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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

November/December 1995

Vol. 88, No. 6



*Medicaid managed care:  
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# INDIANA MEDICINE

The Journal of the Indiana State Medical Association

November/December 1995

Vol. 88, No. 6

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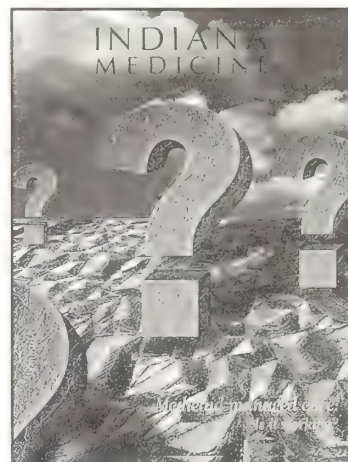
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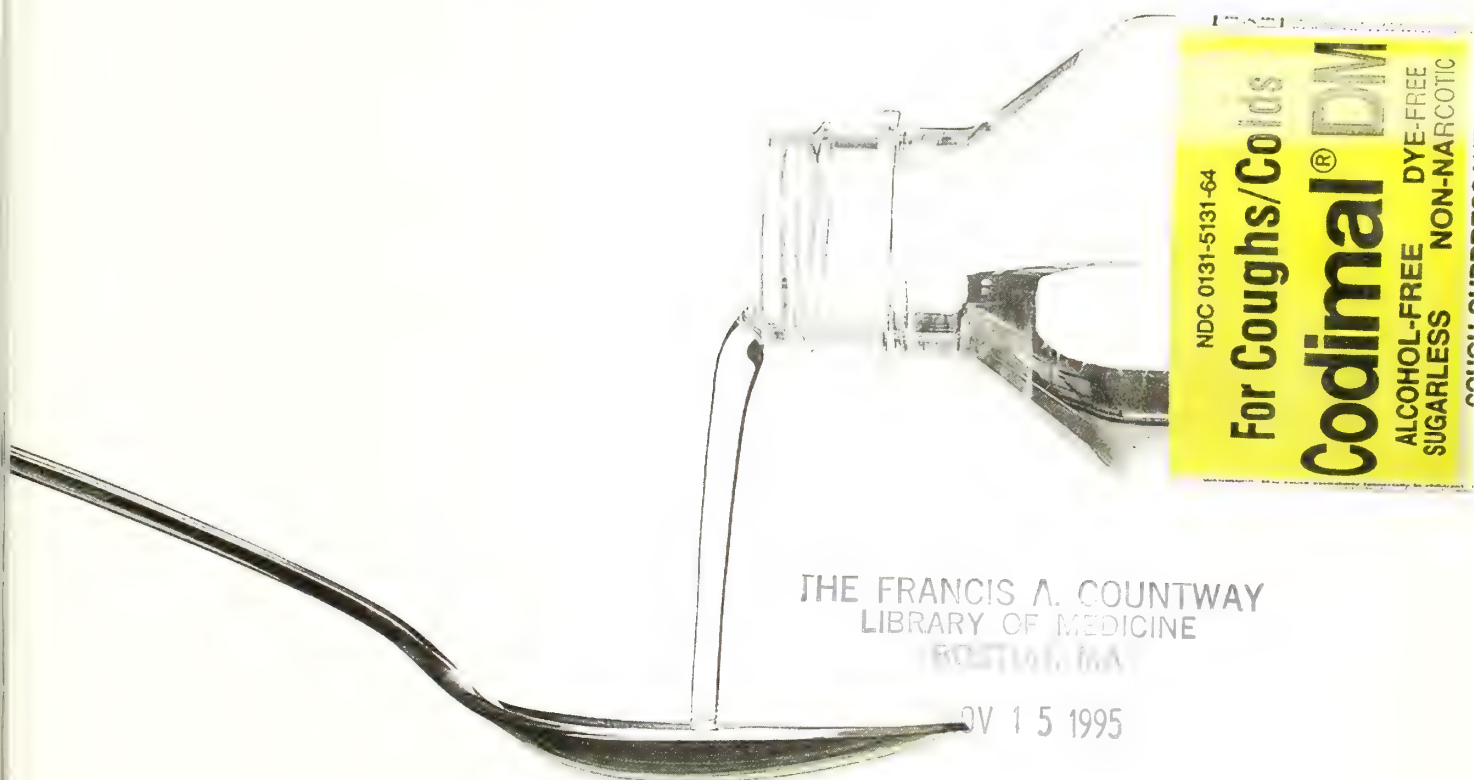
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## **ISMA invites physicians to meet with legislators Jan. 17**

ISMA members can meet with their state legislators during the annual ISMA Medicine Day and the ISMA/IMPAC legislative reception Wednesday, Jan. 17, in Indianapolis. Medicine Day activities will include a breakfast briefing by the ISMA legislative staff at the downtown Embassy Suites, a visit to the Statehouse to meet with legislators and lunch at the Embassy Suites. The legislative reception, from 6 to 8:30 p.m. at the Hyatt Regency Hotel, will transport physicians and legislators to "The Golden Age of Hollywood." For more information, call the ISMA, (317) 261-2060 or 1-800-257-4762.

## **ISMA looking for more legislative Key Contacts**

The ISMA Key Contact Program, which can help make the communication process between physicians and legislators an easy and comfortable experience, is looking for new members. Physicians who join the program agree to contact federal and state legislators about proposed legislation and receive timely information to help them explain the viewpoint of the medical profession. Key Contacts also are invited to special functions where they can meet with their legislators. For information, call Debbie Howell at the ISMA, (317) 261-2060 or 1-800-257-4762.

## **ISMA to offer Medicare and coding workshops in December**

The ISMA will present several workshops in December as part of its practice management series. "Medicare Updates for 1996" will provide information about the participation decision for 1996 as well as the latest Medicare changes presented in the *Federal Register*. Identical morning and afternoon workshops will be held on the following dates in these cities: Dec. 6, Jeffersonville; Dec. 7, Evansville; Dec. 12, Indianapolis; Dec. 19, Merrillville; and Dec. 20, Fort Wayne. "CPT-4/ICD-9 Coding Updates for 1996" will be discussed at identical half-day sessions at ISMA headquarters in Indianapolis Dec. 15. For more information, call Meg Patton or Barbara Walker at the ISMA, (317) 261-2060 or 1-800-257-4762.

## **ISMA represented at AMA political education conference**

Several representatives of the ISMA attended the 1995 AMA Political Education Grassroots Conference in Washington, D.C. Physicians who attended were William Cooper, M.D., Columbus; Alfred Cox, M.D., South Bend; John Knotte, M.D., Lafayette; Barney Maynard, M.D., Evansville; Jerome Melchior, M.D., Vincennes; and Regino Urgena, M.D., Marion. Shirley Becker of Evansville represented the ISMA Alliance. ISMA staff members who accompanied the group were Mike Abrams, Susan Grant and Rick King.

## **New security drug pads must be used starting Jan. 1**

Indiana physicians are reminded that beginning Jan. 1, 1996, all controlled substances prescriptions must be written on security paper, under a new rule passed by the Indiana Board of Pharmacy. The rule was passed in an effort to prevent prescription forgeries and controlled substance diversion. The pads will be printed in blue ink on the front with a watermark stating Indiana Security Prescription on the back. For more information, call the ISMA. □

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# AMA officer: Put

**Bob Carlson**  
**Indianapolis**

**D**aniel "Stormy" Johnson Jr., M.D., has been involved in organized medicine almost as long as he's been practicing radiology. Next June, he will reach the pinnacle of organized medicine when he is installed as president of the American Medical Association.

Dr. Johnson, a diagnostic radiologist in Metairie, La., visited Indianapolis recently to address the Second Congress on Health Care sponsored by the Indiana Public Health Foundation. He also spoke to the Indiana State Medical Association Commission on Legislation and met with John Knot, M.D., AMA vice speaker, and William Beeson, M.D., and Michael Mellinger, M.D., members of the Indiana AMA delegation.

A medical graduate of the University of Texas at Galveston, Dr. Johnson was speaker for six years and vice speaker for five years of the Louisiana State Medical Society House of Delegates and is a former LSMS president. He was elected an alternate delegate to the AMA in 1980 and became a delegate in 1983. He served as vice speaker of the AMA House of Delegates from 1987 to 1991 and as speaker from 1991 to 1994. He has been a frequent AMA spokesperson on health system reform and has testified before Congress.

Over the past eight years, Dr. Johnson estimates that he's devoted one-fourth of his time to organized medicine. When he becomes AMA president, he expects that to increase to half of his professional time.

He co-founded and served as president of the American Society of Head and Neck Radiology. He also is a clinical associate professor of radiology and otolaryngology at Tulane School of Medicine.

Dr. Johnson is a genial, persuasive speaker who comes across as anything but stormy. In this interview with *Indiana Medicine* at ISMA headquarters, he talks about his goals as an AMA leader. He summarizes the AMA's "Transforming Medicare" proposal and compares it with the Republican plan. He explains how making the medical system more accountable to patients would control costs and why he favors medical savings accounts as a means to that end. He also has some thoughts about the future of graduate medical education. Last, but not least, you'll find out how he got his nickname.

**Indiana Medicine: What would you like to accomplish for medicine as a leader in the American Medical Association?**

**Johnson:** The central focus of my tenure is to encourage putting the patient in the driver's seat and to direct accountability of our medical system back to the patient. In much of what we do now, the patient is insulated, is out of the loop. For example, in the most important arena, which is cost, our third party payment mechanisms insulate the patient from the cost of those services, and as a result, we have runaway inflation. Is it any wonder? If you did the same thing in any other segment of the economy, precisely the same thing would happen. So what I'd like to see us do is link the patient to the cost but still protect the patient

against the big hits. What I'd like to see us do is reward people for using this system in a cost-effective way instead of punishing them by taking away their choices. What that means is having market choices, giving patients both the opportunity and the responsibility to make wise decisions for themselves. If they don't like their physician, to change physicians; if they don't like the method of financing, to change it. What that does is make all the players accountable to the patient, instead of taking the patient out of the loop.

**Indiana Medicine: Are you saying let's treat the patient more like a customer in the health care marketplace?**

**Johnson:** One of the problems in looking at a patient as a consumer is the notion, first of all, that medicine is very complex. It's hard for the patient to deal with that and the patient is even less able to deal with choice when the patient is ill. What I'm talking about is having the patient make the decision about who his or her physician is going to be, and what kind of financing mechanism he or she is going to have, when the patient is well. We're not talking about someone standing on the steps of the emergency department clutching his chest with his left hand while he flips through the yellow pages with his right hand to see who does coronary angiography the cheapest. That's not the idea here. Rather, it's to make what Alan Nelson, the executive director of the American Society of Internal Medicine, has called "wise prospective choices." Then, the system knows we've got a patient



# patient in driver's seat

who cares about this; the physician knows we've got a patient who cares about this. And I believe that would make that physician and that plan more attentive to the needs of the patient.

**Indiana Medicine: The AMA has submitted a Medicare reform plan titled "Transforming Medicare." This proposal is a shift from government control and toward personal responsibility, choice, and a marketplace that fosters price competition. How does this plan benefit patients and physicians?**

**Johnson:** Currently, the Medicare program we have is a classic example of price controls that don't work. Think about it. The program itself is bankrupting the government, and yet, the payments to hospitals and physicians for providing the services are frequently below the true cost of providing those services. There's almost nothing good to be said about the financial aspect of the current Medicare system. The positive things about Medicare include the fact that it provides universal coverage for the elderly without respect to any kind of pre-existing condition. All the elderly have access to the system, and currently most of them have a wide array of choices of physicians. But the financing doesn't make sense.

So what's the alternative? Our proposal for transforming Medicare basically addresses that in two ways. First, instead of stimulating people to buy Medigap insurance, we would make traditional Medicare more sensible by having a person pay a higher premium to the government for part B cover-

age, but also pay what we call a refundable deductible of \$500. If the person doesn't use \$500 worth of services during the course of a year, then the part that was saved would come back to the individual. So all of a sudden, it makes the person care about the cost. We take away the price controls, and we would reinstall balanced billing.

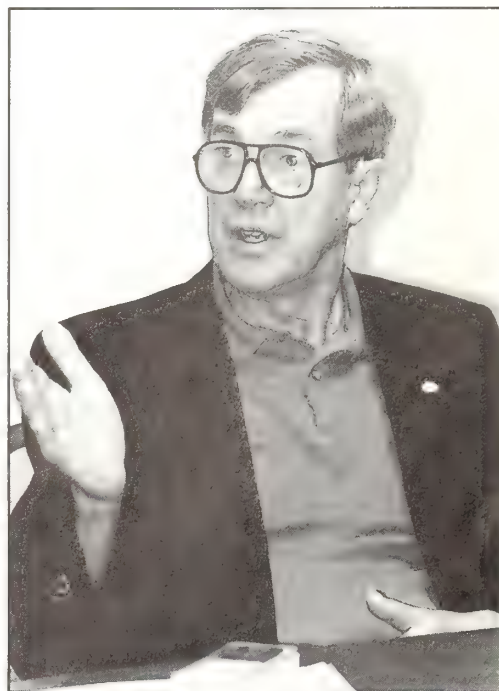
There's a big concern that [providers] would run up the prices. We think just the opposite would happen. We think the cost-effective providers would keep their prices down and they would

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*There's almost nothing good to be said about the financial aspect of the current Medicare system.*

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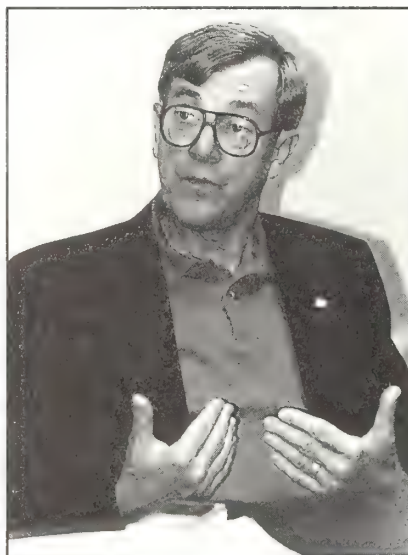
be rewarded. The ones who try to run up the price would be cut out of the loop because seniors would recognize that. We saw that before limits were placed on balanced billing. We would like to reestablish some market principles into the traditional Medicare system, but a better way of doing it is to encourage people to shift over into what we've called "Medichoice." Now, our Medichoice option would be the other side of Medicare. It would mean taking the equivalent of a voucher and going out into the private market and purchasing plans that would be qualified by some entity that would look something like the Federal Em-



ployee Health Benefit Plan. People would pick their particular financing mechanism with the right to change mechanisms at the next enrollment period if it wasn't working out well. We'd like to see the government make the same defined contribution no matter what plan the person picks. If they pick a plan that's less than the government contribution, they realize the savings. If the individual wants to buy a plan that costs more than the defined contribution, it would be up to the individual to come up with the extra money to do that.

We would also have what we call our "triple option" included in the array of choices. Our triple option includes managed care plans, the HMOs and PPOs; it includes traditional insurance; and it includes something we call a benefit payment schedule. Benefit payment schedule means having the insurance plan set a payment for each covered service. If there's a difference between the charge by the physician and the payment by the plan, it's up to the patient and the physician to work out what to do. If the patient says, "Doctor, I can't afford to pay the difference," the doctor could forgive the patient all or part of balance without being accused of committing fraud. If, on the other hand, the patient believes the charge is fair, is fully able to pay the additional amount, this physician should be able to look to the patient to pay the amount without being accused of fraud.

We believe a person should also be able to superimpose a medical savings account that works best with high deductible traditional insurance. It could also work with the benefit payment



schedule, and there may be models where it could work with managed care plans. If the individual is able to create savings, those savings could accumulate in a tax-deferred plan for some future use such as long term care, a nursing home type of situation, or accrue to the patient's estate. We believe a medical savings account is a very viable potential adjunct to whatever choice the person makes in the Medichoice plan.

#### **Indiana Medicine: What are the benefits to physicians in the AMA Medicare Reform Plan?**

**Johnson:** One of the things that's occurring that makes no sense to anyone is the continuing ratcheting down of payments for services by the federal government in a price-controlled system. The Medicare program is a classic example of how price controls don't work. If the fundamental problem is that the patient is insulated from the cost of those

services by a third-party payment mechanism, fixing the price carves that problem into stone because the patient has no concern about the cost. Therefore, the demand is unchecked by any market mentality. It would be like taking a child with a middle ear infection and giving the child Tylenol. You might get some symptomatic relief, but you haven't done anything to the underlying disease process. Our proposal is designed to attack the root cause of the cost problem. In doing so, patients could expect their insurance plan to help them pay appropriate amounts for services rendered by physicians and hospitals, and that would be very beneficial to physicians, to actually be paid what it costs to deliver the service.

#### **Indiana Medicine: What can physicians say to reassure their patients that this AMA Medicare proposal will protect the patient's interest?**

**Johnson:** Many people are worried about being forced into some kind of plan that may not be to their liking. Many Medicare patients are concerned about having someone take away their ability to choose their own physicians. Under our plan, the only way that could happen is if they voluntarily chose to be in a plan that limited choice of physicians, and we think they should have that option. This is not an anti-managed care proposal. As a matter of fact, the managed care plans are an important part of our proposal in the array of choices, and it would be much easier and much more meaningful for someone to get into managed care than is the case today. Managed care plans would



be funded the same as any other choice, on a level playing field, with no incentive either to go into a managed care plan or not, once again putting the patient in the driver's seat. What we propose to do is to improve traditional Medicare for seniors. We would hope that they choose the Medichoice side, where they would have additional potential to save money and yet possibly get the same or better coverage.

**Indiana Medicine: How does the Republican Medicare proposal differ from the AMA proposal?**

**Johnson:** At this moment, all of this is being decided by the Republicans. We believe that they are going to leave traditional Medicare alone, but we don't believe they are going to do anything to make it work better. Conversely, what we think they are likely to do is to get part of the savings they are trying to achieve by further reductions in payments to hospitals and physicians and, of course, we oppose that. We don't think it makes sense, and interestingly, neither does anybody else in the debate, except the Republicans. The reason they're doing it is they want people to go over into the choice side, but they feel it will be sometime before people do that. In the meantime, they are obliged to create budget savings, so they are doing that in what they call the traditional way, that is to say, by provider cuts. We are hopeful that they will realize the folly of what they are trying to do and look at our much more innovative proposal to save the government money but still enhance the traditional side of Medicare.

What's positive about the

Republican proposal and similar to our own proposal is that they do expand the array of choices although they haven't thought to include the kinds of choices that we've advanced. However, they are going to include medical savings accounts. The Speaker of the House, Newt Gingrich, has made it very clear that medical savings accounts are going to become available to both the Medicare population and as well as in the private sector, and we very much applaud that. Now, underlying the debate on the choice issues has been the premise that no other way of financing care would be foreclosed if it could meet the financial solvency requirements of the Medichoice plan. The Heritage Foundation has argued that if you and I got together and had a brainstorm on a new way to finance the delivery of care, we ought to be able to offer it, assuming we can meet certain requirements. I hope that the final language will have that kind of flexibility for innovation.

The major difference in the proposals, as we see it now, derives from the apparent failure [by the Republicans] to make significant changes in the traditional side of Medicare.

**Indiana Medicine: What are the chances that medical savings accounts for both Medicare and private health insurance will be implemented anytime soon?**

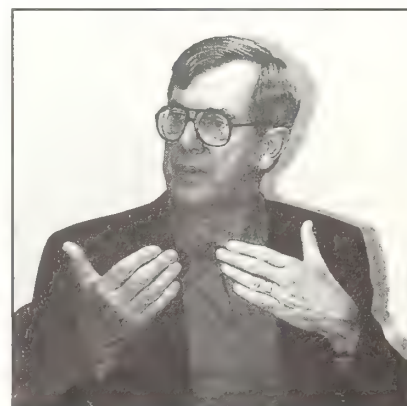
**Johnson:** My optimism grows daily that we're going to see both of those implemented perhaps in the current budget reconciliation activity. There is a separate bill that Congressman Archer has introduced, HR 1818, which would

remove the discrimination currently in place by the federal government, through the tax code, against the person who chooses to have a medical savings account.

The speaker has insisted that the private side will have access to medical savings accounts in the immediate future. He further said that the Medicare population will also have access to those. That is a very important part of their current working version of their proposal, to give seniors access to medical savings accounts. So my confidence level is at the absolute highest it's been since I became interested in the concept of medical savings accounts in the late '70s, almost 20 years ago.

**Indiana Medicine: Let's switch topics here for a moment. What are your concerns about the future of graduate medical education?**

**Johnson:** The federal government has undertaken, over time, a disproportionate share of the funding for graduate medical education through the Medicare program. It's been very generous of the government to do that, but it hasn't made a lot of sense. To some





extent, they do so in Medicaid as well. It would be more logical, we believe, to have an all-payer type of phenomenon where the cost is spread across all the payers so that each is putting forth its fair share. We believe payments from different kinds of financing plans, whether they're managed care plans or traditional insurance or a benefit payment schedule, should contribute to graduate medical education. That's one part.

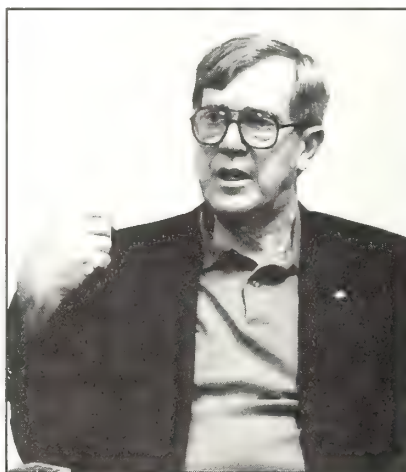
The other part is that it is a greater expense for those institutions who train medical students and train residents than for institutions who do not provide that training. Nevertheless, those institutions which provide the training need to learn how to be more competitive with their counterparts in the private sector who are not doing that. In fact, we are seeing practice plans that are able to change the way they've practiced medicine and financed their delivery of care to patients and to be more competitive. Medical school practice plans are learning how to be more effective. If we have a combination of shared responsibility and more cost-effective delivery of services by educational entities, we should solve the graduate medical education problem.

The other facet, however, that is more difficult to solve, is the entire work force question. We need to determine whether we are producing the desirable number of physicians, not only with respect to one specialty versus another, but whether the entire production of physicians is the correct number to meet the needs of the nation. If it's not, we need to figure out a way, without being accused of professional birth control or anti-

trust activities, to address that question, so that we don't fall into the trap of training a physician who then has no hope of gainful practice once he or she completes a rigorous and expensive process.

#### **Indiana Medicine: How can medical school practice plans become more competitive?**

**Johnson:** One of the medical schools I visited recently was the University of Arkansas. It's remarkable that even though its funding from the state is among the lowest in the country, it has been able to operate in such a cost-effective way that it has built an amazing infrastructure and is adding to it at a time when most institutions are having a great deal of difficulty even surviving. It is to the credit of the faculty members that they have been able to run their institution in a cost-effective way and provide for the needs of those who are sent to them for care in such a way that they can conduct their training mission, not only of medical students, but of their post-graduates, and remain



solvent and even provide for things that most people would argue the state should be providing for them. I give them high marks.

#### **Indiana Medicine: What's their secret?**

**Johnson:** Good management. A clever dean. They go out and get research grants like every other institution. On the other hand, I ran across another institution that shall remain nameless, in a different state, whose payment per medical student by the state was reduced. The response of that medical school was to increase the class size in order to get back to the same number of dollars. I raise the question of whether that makes sense.

The University of Arkansas is a model. They're looking at all the issues of how managed care affects them, but they're doing it in a constructive way so they can be competitive. They've done a better job than this other institution, which is whining about what's happening to it and whining about how they're not competitive.

That's not to say that we as an association shouldn't be committed to adequate funding for graduate medical education, and we have that commitment. It's not to say that research shouldn't continue and that grants shouldn't be available. We support that. But I am compelled to observe that educational institutions, particularly in delivering service to patients, need to change just as the private sector needs to change. They need to be innovative. They need to be focused on how to be more cost effective, how to bring to the system more bang for the

buck, more value.

**Indiana Medicine: Are you looking forward to becoming president of the AMA?**

**Johnson:** I've been an AMA officer for over eight years now. It's been a wonderful opportunity and privilege. The offices that I held before I became president-elect were speaker, and before that, vice speaker. The speaker is one of the most, if not the most, significant figures in all organized medicine, because the job is two-fold. One is to facilitate the ability of the grassroots doctor to have input into the development of policy for the association, and the other is to be the guardian of the process, to see to it that it's fair. That's an enormous responsibility and privilege, and it is one that I enjoyed tremendously. So while the office of president of the American Medical Association is a very nice honor to have and one that I certainly appreciate and by no means take for granted, I have to say deep down in my heart that the job I really loved the most was being the speaker.

Now, I'm proud to be the president-elect, and I look forward to being the president and to being the spokesperson for our profession. I made the fundamental commitment when I was a medical student that I would give back as much as I could to my profession and that outside forces would screw it up over my dead body. I've lived that promise to myself and to my colleagues throughout my academic, political and practice career. I think that ours is a wonderful profession. I will never forget, if I live to be 1,000, the night that I walked across the stage,

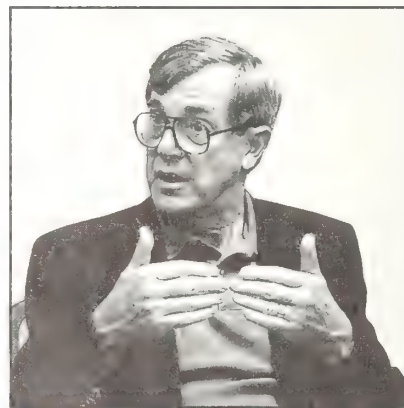
having earned and been given the right to call myself doctor. That continues to this day to be the proudest moment – and when I say proud I don't mean in an arrogant sense, I mean in a humble sense. To have earned and been given that privilege is very special to me. The person in this country who is best able to articulate that pride, on behalf of all his or her colleagues, is the president of the American Medical Association. That's a very special opportunity.

**Indiana Medicine: Would you share with us how you came by your nickname?**

**Johnson:** I've had the nickname "Stormy" since I was two years old. I labored for the first part of my life thinking that I was a very docile child. I have tried to live up to it, but it was only few months ago that my 83 year-old mother told me that when I was a toddler, I was given a new pair of shoes that I liked very much, and I refused to take them off when it was time to go to bed. I put up quite a fuss when my parents tried to take the shoes off, which prompted my father to observe that I was a stormy little character, and that may have been the source for the nickname.

**Indiana Medicine: What do you suppose it is about organized medicine that sparked your interest years ago and obviously continues to interest you very much?**

**Johnson:** I don't think the profession can exist without some way to develop and to articulate policies on behalf of the profession. I'm proud to say that most of our



institutions, our state medical associations and societies, are extremely democratic. The AMA House of Delegates certainly is very democratic, and sometimes that's a burden. But that process rarely makes a significant mistake, and on those occasions, for example, in the AMA House of Delegates, when we have shot ourselves in the foot – and we've done it from time to time – we've repaired the damage at the very next meeting. It's wonderful to have a system that's that dynamic. I believe that there's a tremendous need for, and I think we have in place, a vehicle to provide that kind of policy development.

Another issue is that, understandably, the interests of the radiologist, for example, which I am, are going to be at odds from time to time with the interest of the family physician or the dermatologist or the ob/gyn or the neurosurgeon. There are always going to be different points of view. We need a central organization that offers a forum in which to reconcile those differing points of view, a forum in which someone in one of those disciplines has both the opportunity and the responsi-

bility not only to articulate his or her own concerns, but to sit there and listen to someone else's concerns, instead of having tunnel vision. I can't imagine our profession moving forward without having an organization that can do that.

One of the downsides of having a House of Delegates is that occasionally, they're going to do something that someone doesn't agree with. My retort to that individual is, do you agree 100% with your spouse? Do you agree 100% with your priest, or preacher, or rabbi? Sometimes those things

are very difficult to live with. The same thing is true for the AMA, but the difference between the AMA and your religion, for example, is that in the AMA House of Delegates, if you don't like it, you can write a resolution, submit it to your delegates through your state association, and you may change that policy. It happens. Everything we do in the AMA House of Delegates begins in the mind of one person, and that could be any physician.

I guess I'm an organization person even though I'm a rugged individualist. The idea of having

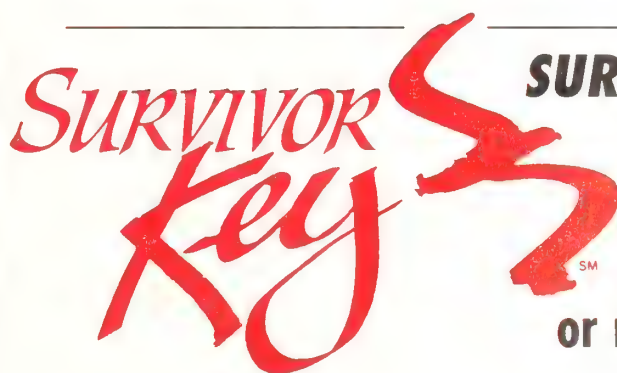
an organization to represent our profession made sense to me from medical school days, even before it was possible for medical students to get involved in organized medicine to any significant degree. Over time the AMA has prospered, has become better, it's become more responsive, it's become more effective. I think it deserves the support of all physicians. □

*The author is a health care writer based in Indianapolis.*



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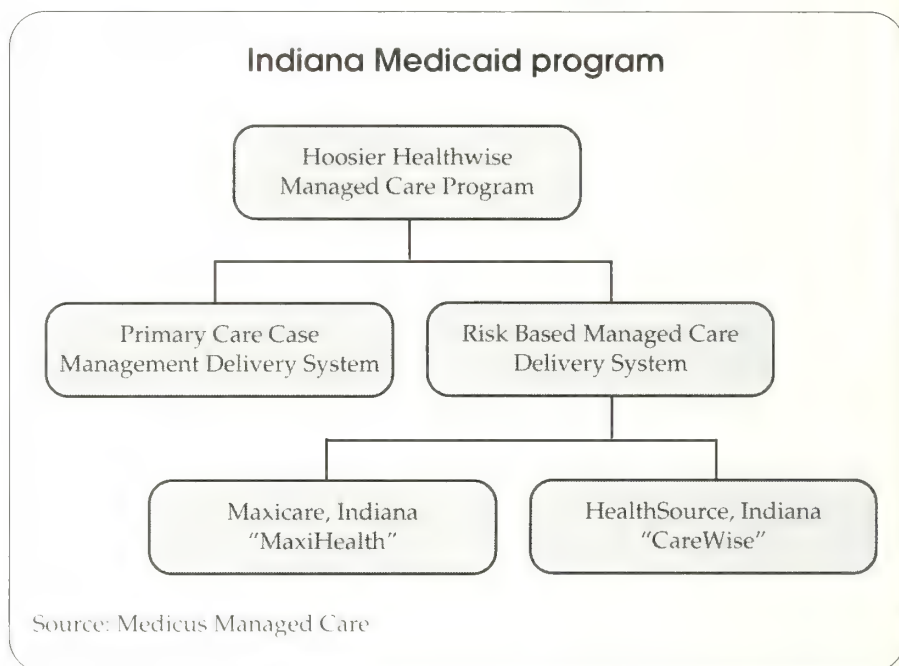
# Medicaid program designed to improve access

Bob Carlson  
Indianapolis

On July 1, 1994, Indiana became the 26th state to implement a managed care delivery system for its Medicaid program. The new Indiana managed care Medicaid program, called Hoosier Healthwise, is designed to enhance recipient health status by ensuring access to primary and preventive care, improving access to all necessary health care services and encouraging quality, continuity and appropriateness of medical care.

Under Hoosier Healthwise, physicians in general practice, family practice, general internal medicine, general pediatrics and obstetrics/gynecology may enroll as a Primary Medical Provider (PMP) in the state-managed Primary Care Case Management (PCCM) network, in the Risk-Based Managed Care (RBMC) network or in both. As the medical "gatekeeper" for Hoosier Healthwise recipients, the PMP provides or authorizes most primary care services and authorizes necessary specialty and inpatient services. Specialists who already accept Medicaid patients do not have to complete a contract with the PCCM network but may be required to contract with a managed care organization (MCO) in the RBMC network.

In the PCCM network, which is administered by the State of Indiana Office of Medicaid Policy and Planning, providers are paid a \$3 monthly management fee for each name on their recipient panel in addition to the standard Medic-



aid fee for service schedule. PCCM physicians assume no financial risk.

In the RBMC network, providers choose to enroll with one of two MCOs and negotiate their reimbursement contract. Currently, provider reimbursement contracts with MCOs include a wide range of choices, from fee for service to full capitation.

Physicians enrolled in the RBMC network do not deal directly with Electronic Data Systems (EDS) about their reimbursement questions. Instead, they work with the MCO.

For recipients, the difference between the PCCM and the RBMC networks is "invisible." Recipients choose a doctor, not a network.

The PCCM provider network is being implemented in specific counties over a three-year period.

First-year counties are Clark, Fountain, LaPorte, Marion, St. Joseph, Tippecanoe, Vigo and Warren. On July 1, 1995, Allen, Delaware, Elkhart, Floyd, Lake, Madison and Vanderburgh counties were added. The remaining counties will join the network on July 1, 1996.

Healthsource Indiana Managed Care Plan and Maxicare Indiana are the two MCOs that will administer the RBMC provider network. Healthsource, which covers all three regions (northern, central and southern) of the state, calls its Medicaid network CareWise. Maxicare, which covers the northern and southern regions, calls its Medicaid network MaxiHealth.

**Patients have a choice**  
When Hoosier Healthwise is



implemented in a county, that county's Medicaid status changes from "voluntary" to "mandatory" with respect to the choices available to Medicaid recipients. Before implementation, Medicaid recipients in a county *may* choose a Hoosier Healthwise physician if they wish; after Hoosier Healthwise is implemented, they *must* choose, or "self-select," a Hoosier Healthwise physician. If a Medicaid recipient fails to self-select a physician within 30 days, that recipient is "auto-assigned" to a Hoosier Healthwise physician.

As you might suspect, making it all work, especially in the start-up phase, is no picnic. In January of 1994, OMPP awarded a contract to Medicus Systems Corporation to assist in implementing and administering Hoosier Healthwise. Medicus responsibilities include provider recruitment and orientation, recipient education and enrollment, hotline operation, utilization review and quality improvement, recipient outreach and follow-up and other public relations functions.

In the spring of 1995, the OMPP and the Medicus Provider Services Team formed the Hoosier Healthwise Clinical Advisory Committee (CAC). The committee is designed to incorporate clinical input from the Indiana medical community into the Hoosier Healthwise policy development process.

In an interview (*Indiana Medicine*, September/October 1993) previewing the implementation of a Medicaid managed care program in Indiana, OMPP Medical Director Denise Ingram, M.D., M.P.H., summarized the goal of the program. "What we're basically trying to do is main-

stream Medicaid patients as much as possible," said Dr. Ingram, "treat them like we treat regular private patients."

The first step toward that goal is the responsibility of the recipient. When Medicaid recipients come in on a rotating basis to be re-determined for eligibility by an DFC (Division of Family and Children) caseworker, eligible recipients automatically participate in an educational session

about Hoosier Healthwise. A Hoosier Healthwise Benefit Advocate (BA) gives the recipient a list of physicians participating in the Hoosier Healthwise program and explains that the recipient must choose one physician from the list as his or her PMP within 30 days. If the recipient's current physician is enrolled as a Hoosier Healthwise provider, that physician's name is on the list. Recipients are also shown a video

### Comparing RBMC and PCCM

#### Risk Based Managed Care

- Physicians contract directly with a managed care organization in their region
- Reimbursement levels are negotiated between enrolling physicians and the MCO
- Physicians work within a specific provider network

#### Primary Care Case Management

- Physicians contract directly with the Indiana Medicaid Program
- Physicians maintain existing referral relationships
- Reimbursement follows the current Indiana Medicaid Fee Schedule
- \$3 case management fee per PCCM patient in your practice each month

Source: Medicus Managed Care

### Electronic Data Systems (EDS)

EDS continues as the fiscal agent for the Indiana Medicaid Program and the Hoosier Healthwise Managed Care Program.

- Provider enrollment into traditional Medicaid
- Provider enrollment into managed care
- Recipient enrollment into Medicaid managed care
- Reimbursement of submitted claims

Source: Medicus Managed Care



about Hoosier Healthwise and provided with printed materials to take home.

Recipients can select their PMPs immediately, or they can mail or call in their selection later. Within 30 days of selecting a PMP, recipients receive a letter confirming their enrollment in the Hoosier Healthwise program, including the name and telephone number of their PMP and their network. The recipient's name also appears on

the PMP's next monthly computerized patient panel. If the PMP is in an MCO, the recipient receives an additional welcome package from the MCO. The PMP's name and phone number are also printed on a sticker that the recipient can affix to his new Medicaid card. Recipients are encouraged to make an appointment with their PMP after receiving their confirmation letter. Recipients may change to another PMP for valid reasons, but are

encouraged to first discuss these reasons with their current PMP before calling the Hoosier Healthwise Hotline or their MCO's Hotline.

### **Building a relationship**

The PMP provides the recipient with routine checkups, preventive services and treatment for more serious disorders. This physician also coordinates all necessary hospital services and refers the recipient to appropriate specialists when necessary. The recipient also has 'round the clock access to the PMP's answering service for medical questions or emergencies. Recipients are advised that they cannot go to another doctor without their PMP's approval and that they should call their PMP first in a medical emergency. If they cannot call because a delay would cause lasting harm or loss of life, recipients are instructed to go to the nearest hospital emergency room. In other words, a Hoosier Healthwise Medicaid recipient has the opportunity to develop the same kind of relationship with his or her PMP that privately insured patients enjoy.

Physicians may enroll in the PCCM network, in one of the two RBMC networks (CareWise or MaxiHealth), or in both the PCCM and one of the two private networks. PMPs may accept a minimum of 150 and a maximum of 2,000 Medicaid patients and may designate a specific number of patients that they will accept. If a PMP is enrolled in both the PCCM program and the RBMC network, the PMP may accept new Medicaid patients in only one network at a time during each three-month period of the calendar year. The physician may switch the network

### **Factors to consider before signing a managed care contract**

Physicians should consider several factors before signing a Medicaid managed care contract:

- Does the contract clearly state on what basis the physician will be paid and the method of compensation to be utilized?
- Is the term of the contract defined and how is the contract renewed?
- How can the contract be terminated and for what reasons?
- What are the responsibilities of each party, and what services are required to be provided by the physician?
- Who owns and has access to the medical records?
- What quality or utilization review is required under the contract?
- Is there any protection against insolvency and is the physician required to render services even if the organization cannot currently pay the physician?
- Identify the current Medicaid population using your services and assess the monetary impact.
- If electing to participate under the PCCM program, decide on the maximum number of recipients your practice is willing to accept (limited to 2,000 recipients per primary medical provider).
- Assess additional revenues/expenses required to participate in the program (i.e., \$3 per member per month management fee vs. cost of swipe cards).
- For capitated RBMC products, compare fee-for-service revenue against anticipated capitated reimbursement based on the frequency of each procedure.

Source: Kameron H. McQuay, Blue & Co., Indianapolis

in which he will accept new patients at the end of that quarter or remain in the same network. PMPs also gain new Medicaid patients through auto-assignment.

All Hoosier Healthwise recipients carry a Medicaid card magnetically imprinted with information, including their current PMP. Passing this card through an electronic "swipe" unit in the physician's office, or entering other recipient identification, instantly shows if the recipient is eligible to receive services from this PMP. This is important for PMPs, because they are not reimbursed if they render service to a recipient who is not in their recipient panel. If a recipient misses a scheduled appointment, the PMP must file a standard claim form. This enables the network administration to follow up with that recipient and avoid future missed appointments.

Physicians with questions about either the PCCM or the RBMC program should call the Hoosier Healthwise hotline, 1-800-889-9949. □

*The author is a health care writer based in Indianapolis.*

### For more information on Hoosier Healthwise

#### Hoosier Healthwise Hotline

Program information and provider enrollment ..... 1-800-889-9949

Recipient questions ..... 1-800-889-9949

#### Electronic Data Systems (EDS)

Reimbursement and claims questions ..... 1-800-577-1278

CareWise ..... 1-800-933-3466

#### MaxiHealth

Northern region ..... 1-800-414-9475

Southern region ..... 1-800-360-6294

#### Automated Voice Response

Recipient eligibility and PMP assignment ..... 1-800-738-6770

#### Clinical Advisory Committee

c/o Medicus Systems

22 E. Washington St., Suite 350

Indianapolis, IN 46204

# Medicaid managed care gets mixed reviews

**Bob Carlson**  
**Indianapolis**

**T**he reviews are in, but the vote is far from unanimous. Medicaid managed care is either confusing, frustrating bureaucracy or a good idea that will improve with time.

Some Indiana physicians who are enrolled as primary medical providers (PMPs) in a Medicaid managed care program complain that Medicaid reimbursement is slow and doesn't cover expenses, that the extra paperwork is burdensome, and that recipient education is not what it should be. Others say these Medicaid recipients need the same care given to other patients and physicians should give the program a chance to work.

Now that Medicaid Primary Care Case Management (PCCM) and Risk Based Managed Care (RBMC) have been in effect for a year, *Indiana Medicine* talked to physicians and program administrators to find out how the program is working so far.

## **'Recipients don't understand'**

Rose Sison, M.D., a pediatrician in solo practice in Terre Haute, is enrolled as a PMP in both the PCCM and the MaxiHealth RBMC networks. Dr. Sison referred *Indiana Medicine* to her office manager, Lita Sison, as the best person to answer questions about her experience with Hoosier Healthwise. If she had to do all the paperwork, explained Dr. Sison, she wouldn't have time to take care of patients.

Lita Sison says she has been working with Dr. Sison for 25 years and knows all of her Medicaid patients. In Ms. Sison's opinion, the program would probably work a lot better if the recipients understood it better. She cites a recent example of a woman who came in with her granddaughter, only to discover that Dr. Sison was not the child's PMP. The woman insisted that Dr. Sison was indeed the child's physician, but an electronic check with the Medicaid office listed another pediatrician as the PMP.

"There was a commotion. She was very upset," recalls Ms. Sison, "but of course we cannot see the child unless we have an authorization from the other doctor, which they would not give because there is no reason for him to refer this child to Dr. Sison since they are both pediatricians."

Ms. Sison believes this recipient failed to select Dr. Sison as the child's PMP and was auto-assigned to another pediatrician. She says she has heard comments from recipients to the effect that they are not about to be dictated which doctor to see and has tried to explain that a physician is automatically assigned to a recipient who fails to select a PMP. "Apparently they don't understand that," says Ms. Sison.

## **'Everybody's still learning'**

Kim Volz, M.D., enrolled in the MaxiHealth network in July 1995. He is one of three physicians in Mount Pleasant Family Practice in Evansville and is also assistant director of the Deaconess Hospital Family Practice Residency Pro-

gram. He mentioned some unresolved issues about being able to seeing Medicaid patients as the assistant director of the residency program and as a private physician, and about residents seeing Medicaid patients. Neither of these issues, however, seems to detract from his satisfaction with MaxiHealth's logistical support and expertise in running a managed care program.

The worst part of the experience so far, says Dr. Volz, is the confusion inherent in switching over to a new health care system like Hoosier Healthwise. When asked if Hoosier Healthwise is achieving its goals, he responded that it's too early to tell, but that it seems to be designed well and he is optimistic that it can work. "I think that it will encourage these patients to utilize health care the same way as private pay patients," he says, "to check with their family physician instead of going to the emergency room for care. From a physician's standpoint, I think that it has the potential to simplify taking care of this population and avoid a lot of the frustration of having these people continually abuse the system. But they have to play by the rules. It's just such a big system and it's new and there's still a lot of misinformation floating around. Everybody's still learning how it works."

## **'Give it a chance'**

Grace Lee Walker, M.D., practices family medicine in Terre Haute and has been enrolled in the PCCM network since its inception in July 1994. Joining PCCM has meant out-of-pocket costs for a



### Primary medical provider enrollment in Hoosier Healthwise

	PCCM	CareWise	MaxiHealth
Year one counties <sup>1</sup>	410	158	15
Year two counties <sup>2</sup>	179	15	153
Contiguous and voluntary recipient enrollment counties	21	15	38
Total	610 (60.76%) <sup>3</sup>	188 (18.73%)	206 (20.52%)

1. Clark, Fountain, LaPorte, Marion, St. Joseph, Tippecanoe, Vigo and Warren. Effective July 1, 1994.
2. Allen, Delaware, Elkhart, Floyd, Lake, Madison and Vanderburgh. Effective July 1, 1995.
3. Percentages are based on the number of primary care physicians that were Medicaid billing providers in 1992.

Source: Medicus Managed Care

new computer system, (so she can file claims electronically), for the electronic swipe machine that verifies recipient information and for an extra telephone line. She would have had to get a computer anyway, says Dr. Walker, because all payers want electronic claims these days. Still, being in the PCCM network means extra administrative work for her and her staff, such as having to file a claim form when a recipient misses a scheduled appointment. She also complains about slow reimbursement for vaccines she administers to her Medicaid recipients.

Dr. Walker agrees that it will take time for Hoosier Healthwise to work better. The biggest challenge, in her opinion, is patient

education. She says many recipients still go to the emergency department or see another physician before they come in for a referral. But she believes that it's as much the physician's job as the state's to educate recipients. Asked if Hoosier Healthwise is achieving its goals, Dr. Walker responds that for her patients and those of colleagues she knows, access to care has never been a problem, nor has quality, continuity or appropriateness of care. She says insurance is not the first thing most doctors look for when they treat a patient. Inappropriate emergency department utilization is still a problem, but she believes it's getting better.

"Hoosier Healthwise is a good idea," says Dr. Walker. "I wish

people would give it a chance. We need to take care of Medicaid patients because if we don't take care of them, another big problem would arise. They're no different than any other patient, in my experience."

#### Hopeful despite problems

Randolph Lievertz, M.D., practices family and addiction medicine in a group of four physicians in the Westside Family Medical Center in Indianapolis. He enrolled in the PCCM network in 1994. Like other PMPs, Dr. Lievertz has had Medicaid recipients assigned to him under the Hoosier Healthwise program who he says had no idea that he was their primary care physician. What's more, he says these patients came from the northeast and east sides of Indianapolis, and his office is on the far west side.

Dr. Lievertz also has a number of other problems with the system. He says there is no category for addiction medicine in the computer system, so he and other addictionologists have to get authorization codes from their patients' primary care physicians even though addiction medicine is an exempt service and does not require prior authorization. He is frustrated that prior authorization is still needed for referrals such as physical therapy, even though he was told that many of these requirements would be eliminated. And he's not happy with the reimbursement rates, which he says average about 47% of his charges, even counting the \$3 monthly per patient management fee.

As more and more people understand the program, Dr. Lievertz believes Hoosier

Healthwise is heading in the right direction. "I think the best aspect is that you keep track of the patient's medical care and coordinate it much better," he says. "Patients who were just going to ERs for acute care are now being brought back into a lower cost system where they're getting their preventive health care. It cuts the utilization down, plus they're getting more education so they can take more responsibility themselves for their own health care."

#### **'Just fix it'**

Other PMPs are less enthusiastic. They say they're losing Medicaid patients they've been taking care of for years, and they're convinced the system doesn't work. Some admit they don't understand how Hoosier Healthwise is supposed to work, that they don't know whom to call, and they're upset that nobody's helping them figure it out.

Douglas Palmenter, M.D., is a pediatrician in solo practice in Evansville. He estimates he has between 1,000 and 1,500 Medicaid patients and has been a Medicaid provider since he started practicing 15 years ago. He is currently enrolled in the MaxiHealth network and the PCCM network, but says it is sometimes difficult to get answers to questions about the Hoosier Healthwise programs. He says his staff can't get through to anybody except Maxicare to get questions answered. He says Maxicare representatives came to his office in July to describe their program, but he has received no information on any other program, other than letters. "I'm sure the patients are about as confused as we are," he says.

"I'm still an active and willing

participant in the Medicaid system," says Dr. Palmenter. "It makes me feel that I'm at least doing my part to provide good medical care for the people who need it. Once these problems are cleared up, I think that Medicaid will be a viable system and patients will be responsive to it."

Jeb Teichman, M.D., a pediatrician in solo practice in Jeffersonville, is enrolled in the PCCM network. He says he signed up because he thought he would lose most or all of his 400 Medicaid patients, or about half his total patient census, if he didn't. While he applauds the concept of managed care for Medicaid patients, Dr. Teichman says it hasn't worked out the way he thought it would. For one thing, he doesn't understand why his pediatric patients need his authorization to see an ENT specialist but have unlimited access to chiropractors. But that's not the worst of it.

"The most frustrating thing is having our patients whom we've been following for years assigned to other physicians," he explains. "The patient then comes to my office unaware that she's been assigned to somebody else and is standing there and I can't see her 'cause I won't get paid. What do I tell this mom with a child who's got a 103 temperature? She should go to see someone she's never seen in her life?"

Dr. Teichman says many of his Medicaid patients don't know what he is talking about when he asks them if they selected him as their primary care provider, and some insist that they did select him, even though they are assigned to another provider. Similarly, Medicaid recipients tell him they don't know they are

supposed to call him for prior authorization before going to the emergency room for non-emergency care. Most of the time, emergency departments don't call him until the next day anyway, he says, but when they do call and he denies authorization, patients get angry and change providers. He says Medicaid recipients need much better education about Hoosier Healthwise, but admits that it's a difficult population to reach.

His message to Hoosier Healthwise?

"Just fix it," pleads Dr. Teichman. "Make it work."

#### **Doctors who declined**

Still other physicians have decided to stay away from Hoosier Healthwise altogether. Kevin Burke, M.D., practices general internal medicine in Jeffersonville and is also the Clark County health officer. He says he has about 200 Medicaid patients currently and sees about 10 a month. Dr. Burke has declined to participate in Hoosier Healthwise because, in his experience, Medicaid has always been a poorly administered program. But his biggest problem has been with the way Hoosier Healthwise was introduced to him and his colleagues.

"The state did a very poor job of selling the program to the physicians," says Dr. Burke. "They sent down a physician who sang the praises of this program, but in response to specific questions was ill prepared to provide us with definitive answers. There wasn't enough information for me to commit myself to the program. So my attitude was, well, there's not enough information and the bureaucrats have again done a



poor job of organizing and educating the physicians about the program. I am not going to get involved in something that is presented in that haphazard and disorganized a fashion. I'm going to stand back and see how it goes before I make a decision. I've seen nothing but absolute headaches for the physicians who have enrolled."

James Walsh, M.D., practices family medicine in Terre Haute. He declined to participate in Hoosier Healthwise because he felt he already had too much paperwork and he didn't want to add more. He also did not want to commit himself to taking care of more patients. "I would have been happy to continue to take care of the Medicaid patients I had, but I was not interested in assuming care for a bunch of new patients," says Dr. Walsh. "My practice is closed to regular patients, and I didn't feel that opening it up to 50, 75, 100 new Medicaid patients was in my best interests. It was a difficult decision, but I just didn't see any alternative."

He says he based his decision on print materials and what he learned from a Hoosier Healthwise presentation to the Vigo-Parke-Vermillion County Medical Society. "I felt it was supposed to be an informative meeting and it was like, here it is, take it or leave it," he recalls. "I didn't feel that we were heard and I didn't feel that [the presenter] had been practicing in day to day medicine. I felt the program needed some major revisions, like the reimbursement for OB care, and they weren't listening."

For James Watson, M.D., the biggest problem with Hoosier Healthwise was that he didn't know what he was getting into.

Dr. Watson is a family practitioner with the Family Practice Center, a six-person group in Lafayette. He says he and other providers in Tippecanoe County were presented with a Hoosier Healthwise enrollment contract that would have obligated them to follow certain rules and regulations. These rules and regulations were specified in the provider manual, but the provider manual was not available at the time the contract was sent.

"Nobody signed up in Tippecanoe County initially that I am aware of," he recalls. "Anyway, it got to be a week before the July 1, 1994, start-up date and [the Medicaid representatives] couldn't understand why providers in other counties were signing up for this program and we in Tippecanoe County were not. Well, we just all kind of independently came to the conclusion that we were going to see what they want us to do before we sign a contract."

### Changes result from doctors' input

**H**oosier Healthwise officials have made the following changes as a result of suggestions from physicians:

- Lowered minimum patient panel size in certain areas based on ratio of providers and recipients.
- Revised OB tests and screenings, increased prenatal and postpartum reimbursement and revised the number of prenatal care visits reimbursed per trimester.
- Producing a training bulletin to help providers bill for Early Periodic Screening, Diagnosis and Treatment services.
- Residents can now do initial assessment. A list is available to recipients and PMPs of residents if the recipient wants to continue care with a particular resident.
- Providers in counties contiguous to recipient mandatory enrollment counties may enroll as a PMP in PCCM to continue to provide care for recipients in those counties.
- Recipients are helped to voluntarily enroll early with their PMP so the PMP can keep at least some of his or her existing patients.
- Recipients are given easier to understand provider lists.
- Now accept physicians with dual specialties in internal medicine/pediatrics as PMPs.
- Physicians can switch between PCCM and RBMC.
- Obstetrician/gynecologists can enroll either as the PMP for pregnant women only or for all women.
- PMPs can enroll and increase their patient panel size in steps.
- Emergency physicians can provide on-call coverage in rural areas.
- Revised system to adapt to providers' scope of practice, such as created more patient age groups.



### Concern about reimbursement

What happened, according to Gary Erskine, executive director of the Arnett Clinic in Lafayette, is that obstetrician/gynecologists and pediatricians in Tippecanoe County made a separate agreement to participate in the Hoosier Healthwise program. One of the features of their agreement is that all providers share relatively equal Medicaid patient loads. Erskine says Arnett Clinic obstetrician/gynecologists and pediatricians have been participating in the PCCM network under the terms of that agreement. As far as he knows, no family practitioners or internists in Tippecanoe County other than obstetrician/gynecologists and pediatricians currently participate in Hoosier Healthwise.

Sharing equally in the Medicaid patient load is important to Arnett Clinic because of the relatively low Medicaid reimbursement rates. As a large multi-specialty group, Arnett already takes a disproportionately large share of Medicaid patients, says Erskine, and Medicaid reimbursement rates average 40% of commercial fees. Nationally, overhead for groups like Arnett Clinic is around 57%, and while Arnett's is not quite that high, Erskine points out that the overhead is higher than Medicaid reimbursement rates. Problems with Electronic Data Systems (EDS), the state Medicaid claims processing contractor, haven't helped, either. According to Erskine, Arnett Clinic is still owed several hundred thousand dollars in Medicaid reimbursements, down from well over \$1 million in early 1995.

"We still are seeing a large number of Medicaid patients," says Erskine. "We see most of them for the entire county. So it's

not like the rest of the physicians at Arnett Clinic, other than OB and pediatrics, aren't seeing Medicaid. They all have a large Medicaid population, large related to the county. I think we need better mechanisms for having the Medicaid patient load being more fairly distributed among all physicians. At least then it'd be fairly done instead of letting people opt out to just not participate at all."

Erskine says Arnett Clinic has been reluctant to participate in the RBMC network because of the financial risk. With more data on which to base a decision and reasonable capitation rates, he says that would be the direction in which Arnett Clinic would like to head.

Dr. Watson has not closed the door to future participation in

Hoosier Healthwise, either. "We would be open to a re-evaluation if all the rules were specified in the beginning, so we could figure out if that was compatible with our method of practice," he explains. "We are interested in managed care. We're working with other managed care insurance vehicles."

### Hoosier Healthwise response

Wendy Bokota, director of managed care operations in the Office of Medicaid Policy and Planning (OMPP), has heard every possible complaint about Hoosier Healthwise — many times over. From her perspective, providers understandably didn't really start to ask a lot of questions until the program was implemented. Nobody really believed that Medicaid was going to implement

## Primary Medical Providers (PMPs)

### How to become a PMP

- Comply with all pertinent Medicaid regulations and state standards
- Specialize in one of the following areas:
  - General practice
  - Family practice
  - General internal medicine
  - General pediatrics
  - Obstetrics/gynecology (for all women or pregnant women only)

Physicians must sign the PCCM contract addendum or contract with an MCO to enroll as a PMP.

### Responsibilities

- Coordinate access to all medically necessary services
- Available to see PCCM patients at least 20 hours a week at each practice location
- Accept 150 to 2,000 Hoosier Healthwise patients
- Provide telephone access 24 hours a day, seven days per week

Source: Medicus Managed Care

managed care, or that it would be implemented as quickly as it was. She says physicians were approached early on for their opinions, but that they weren't able at that time to assess the impact the program would have on their practices.

"That's an unfortunate problem and we're trying to make up for that fact by continuing to educate providers and get input from them, especially through the clinical advisory committee," says Bokota. "We welcome as much provider input as possible and we change policies because of their input. Those are lessons we've learned. In fact, we really designed the program with the intent that it would continue to evolve as we sought input."

This is a point she comes back to several times. Even with the benefit of experience from other states who have already implemented managed care Medicaid programs, Bokota says they never expected to get Hoosier Healthwise right the first time. Every state is different, and even within Indiana, what works in Marion County may not work in rural areas. As in other states, the program continues to change as it is phased in over time, thanks in large part to comments and suggestions from providers. For proof, she points to a growing list of policy changes that are the direct result of provider input (see box on page 433). This fall, the first Hoosier Healthwise Provider Satisfaction Surveys and Recipient Satisfaction Surveys were sent out. Survey results are expected in late 1995.

#### **Education: role of Medicus**

Medicus, the company contracted by the OMPP to assist in imple-

menting and administering Hoosier Healthwise, is also working to improve the program. Fifteen years ago, Medicus developed, and still manages, an HMO system for the indigent population in San Diego County, Calif. Medicus also has a contract in Colorado and with other state and local governments to develop managed care programs for Medicaid populations.

Robert Armbruster, provider services manager with Medicus, describes the educational mission as two-tiered, targeting both providers and recipients. For recipients, the effort begins when benefit advocates (BAs), who are actually Medicus employees, orient Medicaid recipients in Division of Family and Children (DFC) offices throughout the state about Hoosier Healthwise. That includes emphasizing the importance of primary and preventive care services, explaining how to use services appropriately and helping recipients select a primary care physician. Armbruster emphasizes that it is this last step that actually enrolls a recipient into the program. He also acknowledges the difficulty.

"We're taking frequently the poorest educated and the poorest utilizers of the health care system and trying to force them into a delivery system that is often the most trying for any participant, whether it be on the commercial side or on the public assistance side," says Armbruster. "It's trying for providers, but it can be even more trying for the patient."

One measure of how well the educational effort is going, according to Armbruster, is the proportion of recipients who self-select their PMP versus those who are auto-assigned. When Hoosier

Healthwise started, auto-assignments were around 65%. Currently, only 25% to 30% of the population are being auto-assigned. In other words, about 75% of the people who are enrolling in this program are choosing their own doctor, says Armbruster. He adds that many recipients who are still being auto-assigned have never had a primary care physician.

#### **Committee takes suggestions**

Provider education includes a quarterly newsletter entitled *Hoosier Healthwise Headlines* and other print materials, a full schedule of presentations at clinics, hospitals, county medical societies, and individual physician offices throughout the state, and the calls and letters that providers direct to the Medicus Provider Assistance numbers and to Armbruster himself. For PMPs enrolled in the RBMC networks, additional educational resources are available from Healthsource and Maxicare, respectively. Armbruster is especially pleased about the Clinical Advisory Committee (CAC), which was formed early in 1995 and meets every other month. Armbruster and Bokota emphasize that the CAC is where providers should address their suggestions for changes in Hoosier Healthwise policies.

One policy change eliminated the inconsistency between Hoosier Healthwise regulations and American College of Obstetricians and Gynecologists (ACOG) standards for prenatal care that Dr. Walsh mentioned earlier in this article. Another, initiated by Tippecanoe County providers, means PMPs can increase their patient panel size in steps. Several policy changes make it easier for



providers to keep their existing Medicaid patients.

"Patients are never taken away," says Bokota. "That is misinformation. Doctors have every opportunity to keep their own patients. The doctor needs to help the recipient choose him. If a patient has been assigned to another doctor, all the patient need do is call the hot line and they will automatically be switched back to the relationship they have with their doctor. If they don't call us, we have no way of knowing."

Bokota adds that frequently providers aren't aware that their patients may be seeing a number of doctors. When a patient chooses one PMP with whom to maintain that relationship, one or more other providers may feel they have "lost" that patient. She concedes that a good number of Medicaid recipients throw their orientation materials away, never do anything about it and end up being auto-assigned. But she says that a provider can always have the patients he wants as long as those patients want him as well.

Bokota and Armbruster admit that the problem of unauthorized visits to the emergency department continues to challenge the system. With recently passed state legislation that reimburses emergency physicians for triage, or medical screenings, the incentives for keeping non-emergency Medicaid patients out of the emergency department are somewhat backwards, Bokota says. According to Armbruster, the focus right now is on more recipient education about the emergency department. Medicus is also working with the American College of Emergency Physicians, Indiana Chapter, to develop

informational pamphlets that emergency departments can give to recipients who utilize emergency departments inappropriately.

His message to Indiana physicians?

"I think it's very important that physicians receive correct information," says Armbruster. "Secondly, I would ask physicians to give the program a chance. We are by no means perfect, but we are improving and we are trying to make things better. Medicaid is a whole different game now than it used to be, and the Office of Medicaid Policy and Planning is really dedicated to responding to physicians' and recipients' concerns. That's one reason why they've moved to managed care, to adapt more to what's being done on the practice side and not just push a government mandated program."

"We need to work together," adds Bokota. "Some form of managed care is inevitable. That's the way it is on the commercial side and that's what we're doing for the Medicaid population. In the long term, this is a health care system that's going to greatly improve the care that's provided for this population."

Most Hoosier Healthwise providers, even those who have good things to say about the program, complain about the low reimbursement rates. Still, 1,000 Indiana physicians have enrolled so far in Medicaid managed care. One reason may be that Hoosier Healthwise offers physicians a choice of competing networks.

Because it is managed by the state, the PCCM network inherits much of the ill will for Electronic Data Systems (EDS) slow claims

processing and reimbursement that has plagued the system long before Hoosier Healthwise came along. Many providers are still waiting for money owed them for Medicaid claims they submitted months ago. One PCCM provider says she won't renew her contract until she gets paid what she'd owed.

"From my perspective, a lot of improvement has been made," says Bokota. "We know that because the number of phone calls that come in and the number of claims that are being denied are going down. We want to take the focus off of reimbursement and all the different day-to-day operational activities that we know continue to need work. If we think in the long term, this is a health care system that's going to make a big improvement in the care that's provided for this population."

The most recent figures available show that 610 physicians, or 60.76% of the number of primary care physicians that were Medicaid billing providers, were enrolled in the PCCM network. One PMP says she enrolled in the PCCM network because she didn't want to work with an insurance company. She also says there's not much difference between non-Medicaid commercial reimbursement rates and what she's reimbursed as a PCCM provider. Another PMP is convinced that PCCM is the best deal financially because the \$3 per patient monthly management fee is better than what he was offered by an MCO.

"Some form of managed care is inevitable, and the most basic component of that is a gatekeeper function, which is really what PCCM is all about," says Bokota. "It's a traditional fee-for-service



program with a gatekeeper function. That's the way it is on the commercial side and that's what we're doing for the Medicaid population."

### **CareWise network**

Healthsource covers about 3.7 million lives nationally, and 112,000 lives in Indiana, of which 21,000 are patients of providers in its CareWise Medicaid network. Healthsource has Medicaid experience in New Hampshire and Tennessee and has just been awarded contracts in Connecticut and New York.

According to David H. Smith, CEO of Healthsource, recruiting providers has been slow going. In early October 1995, 133 providers were enrolled in Carewise in Indiana. Smith ascribes physician caution to bad experiences with the traditional Medicaid program and frustration with low reimbursement and red tape. He says that in some areas of the state physicians are just walking away from Medicaid. On the other hand, Ohio and Michigan had the same kinds of problems when they rolled out their programs, says Smith, who has 15 years of Medicaid experience in those two states.

He is enthusiastic about a new CareWise reimbursement model that was introduced to physicians in October. According to the model, reimbursement for CareWise providers could rise 15% to 20% above current Medicaid fee-for-service rates if inappropriate utilization and abuses in the Medicaid program are reduced. Instead of paying the hospital \$200 or \$300 for treating a child's runny nose in the emergency room, for example, that child could be treated for the cost of an office visit

with a primary care physician. Smith says the savings would help finance higher reimbursement rates for providers enrolled in the CareWise network.

Smith emphasizes that in the RBMC network, physicians deal with their MCO's authorization, claims processing and reimbursement systems, not the state's. He says CareWise normally pays its claims in 14 days. And with full capitation, he adds, there are no claims to submit.

"I think that risk-based programs are definitely here to stay and probably the wave of the future for physicians," says Smith. "In a risk-based program, they can pretty much design the program themselves versus trying to work through the state's red tape. We're very open to physicians' comments on how to improve the system. I think that we can all partner very well together with the risk-based program."

### **MaxiHealth network**

The MaxiHealth network has been paying its providers more than providers in the PCCM network all along, according to Vicki Perry, vice president and general manager of Maxicare Indiana.

MaxiHealth providers also may benefit from an ongoing effort to make their eligible Medicaid patients aware that as Hoosier Healthwise recipients they can maintain the relationship with their physician by selecting him or her as their PMP, instead of being auto-assigned to another physician. Perry says Maxicare also promises faster service and claims processing than EDS.

Maxicare Health Plans covers 325,000 lives nationally and approximately 100,000 in Indiana.

As of October 1995, almost 14,000 Hoosier Healthwise recipients were patients of providers in the MaxiHealth network. Maxicare also has Medicaid experience in California and Wisconsin.

By early October 1995, approximately 250 physicians had signed up with MaxiHealth, which was awarded only the northern and southern regions of the state. Perry acknowledges that many physicians regard managed care with suspicion, especially in the southern region, where managed care has not penetrated as rapidly as in central and northern Indiana.

"Working with an organization such as ours gives a physician some familiarity, some experience and some expertise with managed care products without demanding in year one that they assume risk and be on cap. I think over the next three to five years we're going to see more and more managed care product options, certainly with state and federally funded programs, as well as many large employers moving more and more of the patient base into managed care products," says Perry.

### **Prerequisites for success**

No matter which Hoosier Healthwise network you join, the comments of physicians in this article point to several prerequisites for success. You need a computerized practice management system. You need a knowledgeable, well-trained staff to work with recipients and handle the administrative responsibilities that come with the program. And you have to be able to negotiate a contract you can live with. □

*The author is a health care writer based in Indianapolis.*

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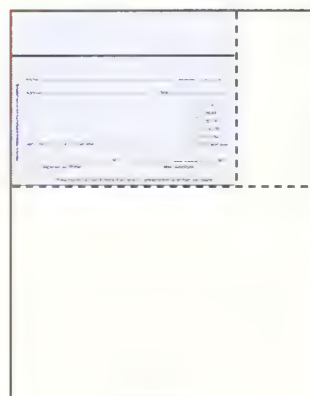
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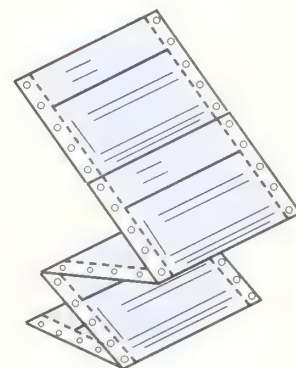
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# Maintaining confidentiality of computerized medical records

John J. Wernert, M.D.  
Indianapolis

Medicine is a profession steeped in tradition and history. Dating back to the times of Hippocrates, the basic tenets of medical practice have been maintained and passed on from generation to generation of physicians. One of these most basic of medical values is the sanctity of the doctor/patient relationship and the confidentiality of the communication between the physician and the patient.

Every day, physicians discuss and record information about patients. Each patient encounter takes place against a backdrop of trust. The physician must respect the confidential nature of patient communication, whether spoken by the patient, written on an office form or obtained from a test or diagnostic instrument. History has taught us that such a spirit of respect and confidentiality is necessary for quality care to take place. If there is a perceived danger of harm from disclosure or misuse of information, the patient might falsify information or refuse to comply with treatment. Inappropriate disclosure of medical information can lead to loss of one's job, loss of insurance coverage, damage to one's career or severe social embarrassment.<sup>1</sup>

Indeed, medical providers have a duty of confidentiality. The American Medical Association states that "information disclosed to a physician during the course of the relationship between the doctor and patient is confidential to the greatest possible degree ..."<sup>2</sup>

## Abstract

One of the most basic medical values is the sanctity of the doctor/patient relationship and the confidentiality of the communication between the physician and the patient. Another important medical tradition is the production and maintenance of an accurate medical record. In today's health care market, the needs of the payers, the providers and the patients have driven the development of the computerized patient record. The primary advantage of a computerized medical record is the ability to store vast amounts of information and handle the data more efficiently. Such speedy access to data can benefit patient care, but it also threatens the patient's privacy and right to confidentiality.

Security of the computerized record poses more of a challenge than protecting the traditional paper chart. There currently is no comprehensive federal legislation dealing with the privacy of a citizen's electronic medical record. It may be necessary to sacrifice some individual privacy in order to receive the benefits of a computerized record. Risks to this confidentiality are many, but can be generally, but not totally, controlled. Acceptable responses to these threats combine technological and practical measures. It is the provider's responsibility to inform his patients of the limitations of security measures and to warn them of the potential threats to maintaining confidentiality of the medical record. □

Another important medical tradition is the production and maintenance of an accurate medical record. Vast amounts of patient information are generated and consumed daily in the clinical setting. For decades, this clinical information has been recorded with antiquated pencil and paper methods, usually in the patient's chart at the bedside or in the office. The written chart was sufficient when technology was limited. The chart usually consisted of the observations and musings of the physician, serving mainly to remind the provider of important facts about the patient's history or physical findings.

However, as medical technology has advanced over the past 20 years, the need to collect, collate and report patient data has grown.

The practice of medicine in the 1990s has become as information-intensive as many businesses and major industries.<sup>3</sup> The amount of data generated by a single hospital stay or outpatient evaluation is staggering. The advent of widespread computerization held great hope for medicine, especially in its most fundamental configuration as a tool for collecting and processing information. Despite continued resistance in some sectors and by some physicians who view computers as too tedious or expensive, the computerization of medical information moves on.<sup>4</sup>

The use of information systems has become so widespread in medicine that hospitals have staked their very financial existence on the ability of computers to improve productivity, heighten

clinical efficiency and document quality of care.<sup>5</sup> Insurance companies and managed care organizations are completely dependent on the computer link to monitor utilization and track patients.<sup>6</sup> Many physicians today realize the significant advantages computerized information systems have over manual methods and are using computers in their offices in new capacities other than billing.

The needs of the payer, the provider and the patient have driven the development of the computerized patient record, which captures medical information and makes it available to those who "need" access. Ultimately, such speedy access to data can benefit patient care, but it also threatens the patient's privacy and right to confidentiality. With the globalization of computer networks and information systems, the risk that medical data are shared across organizational boundaries is even greater. If sensitive data get on the vast "information highway," the risk to an individual's confidentiality is enormous. With the implementation of each electronic patient record comes an inherent conflict; how to protect the very individuals a computer database is designed to serve.<sup>3</sup>

Will computers and confidentiality collide on the information highway?

#### **Advantages of a computerized medical record**

Physicians use tools every day to perform their special tasks. It is difficult to believe, but the computer may eventually take the place of the stethoscope as the most often used "tool" in the physician's daily routine. Many

physicians obsess over the question of whether or not to use the computer as a tool in their practice. Some providers resist because of the expense involved in computerization or ignorance of the advantages.

Yet, the trend towards computerized medical record keeping is clear. Four distinct advantages may be expected when medical information systems are used: 1) direct and rapid access to patient information, without relying on ancillary staff; 2) direct order entry, thereby reducing manual steps and potential for error; 3) storage of diagnostic and treatment information; and 4) thorough documentation of patient care activities.<sup>4</sup>

Such advantages do not wrest control of the patient's information away from the doctor. On the contrary, such information systems help physicians take control of their practices by bringing necessary patient care information to the office and placing it literally at the physician's fingertips.<sup>4</sup> Delays and inefficiencies associated with phone calls to labs, pharmacies and physician offices can be minimized. The physician is well-informed and therefore can exercise better clinical judgment.

The use of electronic medical records allows practically unlimited amounts of data to be saved. This medical information is not merely recorded in files. Data are read, changed, collated, aggregated, compiled and copied. The ability to access a single patient's record is clinically helpful for that patient, but the ability to access many patient records can have a profound effect on larger managerial issues.

For example, quality manage-

ment programs often require systematic, efficient collection of information that can be extracted only from patient care files. Doing this by hand with paper charts is exhausting and at times futile, depending on how bad the handwriting is. Taking data from entire patient populations allows the development of "report cards" on individual providers, hospitals and systems. Computerized quality management initiatives have only intensified demands for information about quality, performance and outcome. Many managed care companies require this information before accepting a new provider in to their panel. Could individual physicians provide such information on their own?

Most experts agree that there will always be the need for a "hard copy" of important documents. However, the sheer volume of documents generated in a typical medical practice is overwhelming. The primary advantage of a computerized medical record is the ability to store vast amounts of information and handle the data more efficiently.

Most states have statutes that cover the handling, maintenance and release of medical records. In Indiana, health records are covered under Indiana Code.<sup>7</sup> I.C. 16-39-7 requires that providers maintain "... the original health records or microfilms of the records for at least seven (7) years." X-ray films must be maintained for at least five years.<sup>7</sup> Hospitals and physician offices shoulder great expense storing and maintaining paper records. Eventually, computerized storage of medical information (including actual x-ray images) will do away with this expensive



and space-occupying requirement.

The computerized patient record is an invaluable tool that helps physicians deliver well-documented, consistent quality care. Computers are not futuristic; they can do only what man can do, and do it much faster. Health information systems will not correct errors in the doctor's judgment, nor take control of clinical decision making. Rather, the computer should be used as a tool that manages clinical information in a more efficient way and helps produce more positive outcomes for both the doctor and the patient.

**Is confidentiality at greater risk with computerized records?**

Privacy protection is one of the major issues in the development of clinical information

systems. Privacy and confidentiality of patient information become even more difficult in the development of multi-institutional or system networks.<sup>8</sup> Yet, is the risk to confidentiality any worse than in a paper-based environment? Consider that confidential information has and continues to be revealed inadvertently by caregivers or their support staff, overheard in hallways or inappropriately read in a chart left on a desktop. In fact, breaches of confidentiality may have nothing to do with automation. Several authors, including those writing for the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) have found that most cases of actual harm involving individuals arise from manual records.<sup>1</sup>

Many people raise the concern about the potential for damage to confidentiality because they may not fully understand the technology or the safeguards that are available. Some concerns are created simply because electronic databases are more compact and easier to access. Indeed, problems with security and privacy are magnified for automated records because there are multiple sites of access, whereas a paper chart has only one locale. Security becomes an issue when information becomes easily accessible. A person

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***Privacy and confidentiality of patient information become even more difficult in the development of multi-institutional or system networks.<sup>8</sup>***

---

could conceivably copy a patient's records onto a tape or disk and walk out of the hospital much more easily than he could with an equivalent paper chart. Also, security of sensitive data becomes increasingly problematic the larger the database becomes. Curious family members, "hackers" and disgruntled employees may find such information irresistible. Information may be especially vulnerable when transmitted between provider systems, as in referrals, or when databases are opened to dial-in access from authorized users from home. Therefore, such electronic data must have strong automated

protection mechanisms and comprehensive organizational policies and programs.<sup>1</sup>

The paper medical record is not nearly as private as many people surmise.<sup>9</sup> With the chart in a paper environment, there is no trace or record of who looked at or reviewed the material. Almost anyone with a white coat could walk into a hospital unit, pull a patient chart and review it. At least with computerized records, a log or accounting of who accessed the information can be kept. When assessing the breaches of confidentiality, the computerized information system can at least measure the loss of privacy.

It may be necessary to sacrifice

some individual privacy to receive the benefits of a computerized medical record. An example would be the loss of some privacy we all experience by having our addresses and phone

numbers printed in phone books and directories. We may lose some privacy but gain some substantial benefit. So it is with computerized medical records.

**Can privacy protection be legislated?**

Judicial decisions in the United States have confirmed the patient's rights to protection of a "reasonable expectation of privacy."<sup>8</sup> Patient records are currently protected by federal confidentiality rules (42 CFR Part 2). These federal rules give guidelines concerning expressed and written consent by the patient for release of records and prohibitions concerning



further disclosure of confidential information. However, there is no U.S. case law regarding the computerized medical record, mainly because no one in this country has been prosecuted for defiling or breaking into an electronic medical record.<sup>3</sup> There currently is no comprehensive federal legislation dealing with the privacy and protection of a citizen's electronic medical record. The experiences in other developed countries have been varied. Most Western countries have statutes for the protection of the individual's medical data. Finland, for example, has formal legislation that attempts to regulate the practice of data processing. The legislation outlines the rights of the patient and the obligations of the institutions and providers.<sup>10</sup> On the other hand, several countries, such as Belgium, have no statutes or regulations and have had embarrassing problems with this lack of medical data protection.<sup>10</sup>

Breaches of security may also create other adverse legal consequences. If a computerized patient record lacks sufficient security in design or operation, a court may find that the records are unreliable and cannot be used in court. This could devastate a physician's defense to a malpractice claim or could harm a patient's case if health status is at issue.<sup>11</sup> If patients are harmed because their records are compromised, there could be liability exposure for the provider, generating possible reimbursement and peer review problems.

Just in the past year, legislation came before the U.S. Congress that would have threatened the confidentiality of mental health

records.<sup>12</sup> Given names such as "administrative simplification" and The Fair Health Information Practices Act, the proposed legislation would have created a national system of computerized medical records and replaced existing state laws governing confidentiality and disclosure of information. The federal legislation would have given law enforcement agencies access to medical records without requiring a court order, and all disclosures of confidential information could have been made without notification of the treating psychiatrist. This proposed legislation fortunately died along with the health reform initiatives in the 103rd Congress.

The standard of computer security legally required for computerized patient records systems is not always clear.<sup>11</sup> As computerization goes forward, federal legislation will be necessary to address issues of patient confidentiality and privacy. Until such legislation comes on line, it is up to the individual providers, physicians' offices and health care organizations to institute strict guidelines and policies dealing with the handling of confidential data. Information security programs should be utilized.

#### **Protecting confidentiality**

Health care providers and organizations must acknowledge their ethical and professional duties to respect and safeguard the confidence of the patients they care for. This must include taking measures to ensure that the patients' computerized medical records are secure and protected.

Security for a patient record system should be designed to

balance the need for confidentiality against the need for easy access by those involved in patient care. For users of the system, a security system should permit only authorized users to access the records. This can be accomplished through a system of passwords and key cards. The newest technology of biometric identifiers is generally too costly, but would be ideal for ensuring authorized access only.<sup>11</sup> A hospital or medical practice should have strict policies against disclosing passwords or sharing access codes. Passwords should be changed frequently, and a user should be permitted to log on to only one user device at a time. It is also advisable to limit the access of users to the portion of the patient record related to their work. The computer should restrict access to particularly sensitive data, such as lab results for AIDS or mental health/substance abuse reports. If persons attempt to access information beyond their clearance, the system should lock them out until a supervisor allows them re-entry. Such measures would add an additional layer of accountability for those attempting to probe beyond their authorized limits.

Many people may desire access to these records, including insurers, finance and billing departments and even the patients themselves. However, medical personnel are the only ones who have a legitimate right and need to see confidential information in order to care for the patients. Even though insurance carriers and payers have a vested interest in the information, these entities can lawfully obtain such information without resorting to an electronic record.<sup>3</sup>

It is much more difficult

protecting the health information system from "hackers" and disgruntled employees. Often described as curious and mischievous, hackers can do significant damage to a record system. Some have been downright malicious, even planting computer viruses into systems. Terminated employees with intricate knowledge of the system and its security can also do substantial damage if measures are not taken to neutralize their expertise. This should include immediate change of passwords, heightened security at all access points and close monitoring of any unauthorized requests for access to the system. Hardware and software security systems can be quite expensive and difficult to maintain. A security consultant may be necessary to safeguard the system and should be retained before proceeding with the termination of the problem employee. The expense of a consultant would be cheap in comparison to a crashed system. Remember, inside users often pose the biggest threat to system security.<sup>11</sup>

Preventing unauthorized access to patient records that can be accessed from multiple or remote sites is much more difficult than preventing unauthorized access from one location. Telephone access makes it possible for outsiders to try repeatedly to gain access without being visible to the practitioner using the system. Wireless technology and wide-area networking create another unique confidentiality problem, since the patient information is being transmitted through public channels, such as airwaves or

phone lines. If this mode of networking is highly used, encryption of patient data should be considered.

The provider must also be wary of third-party vendors and consultants used in developing the record system. These third parties may be involved in installing, operating and supporting the patient record system. These parties have neither the legal nor ethical obligations that practitioners have regarding confidentiality. If confidentiality is breached by permitting a third-party access to records, the provider can be held responsible for disclosure unless the provider had taken all reasonable precautions to prevent the disclosure.<sup>11</sup>

### Conclusions

Patient records must be computerized in such a way as to preserve their confidentiality. This is a daunting challenge! Risks to this confidentiality are many but can be generally, but not totally, controlled. Acceptable responses to these threats combine technological and practical measures. Factors such as the costs of security systems and the necessity that records be accessible to the authorized health professional will sometimes conflict. It is the provider's responsibility to inform patients of the limitations of security measures, and to warn them of the potential threats to maintaining confidentiality of the medical record.

Computers and confidentiality may create some friction on the information highway, but with proper planning, wise choices in

policy formulation and the application of technology, a collision can be avoided. □

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# How can you maximize your retirement income from appreciated assets?

Joel M. Blau, CFP  
AMA Investment Advisers

As you approach your retirement years, the focus of your investment plan shifts from accumulation or growth to income generation. The income from interest and dividends generated from your portfolio will act as your "paycheck" during retirement. A problem occurs when growth investments do not provide an adequate amount of income. In this case, many retirees sell low dividend paying stocks or real estate to buy income producing bonds or bank CDs. If the assets sold have a fairly low-cost basis relative to its current value, you will be liable for the capital gains tax upon the sale. The tax reduces the amount that would be available for reinvestment into income generating vehicles, which ultimately reduces your retirement stream of income. However, there is a way to shift the gain to a charitable organization and maximize your future income stream. This can be accomplished through estate tax planning strategies today.

At death, your estate is allowed a full deduction for the value of property that is transferred to qualifying charitable organizations. These charitable donations can be in the form of outright bequests, or through partial interest gifts. An outright bequest would be a gift of cash or property without any retained interest by the donor. An example of a partial interest gift is usually in the form of a charitable remainder trust. With this type of trust, the donor retains the right to the income of the trust for a certain period of years or for life. At death, the charitable organization receives the trust principal. This strategy allows the donor to enjoy the income from the asset while living and to make a meaningful charitable contribution at death as a bonus.

For tax purposes, the donor receives a current income tax deduction for the value of the remainder interest, which passes to charity at death or termination of the trust. Gifting appreciated property, such as stocks or real estate, creates benefits to the donor that are irreplaceable. Based on current tax law, the charity can sell

the appreciated asset and not be liable for any tax. The full proceeds from the sale can then be used to purchase income generating investment vehicles, of which the income stream can supplement your retirement income needs.

By combining all of the tax saving strategies, an individual could theoretically bequest the entire estate to charity and avoid estate taxes altogether. However, most people would prefer to pass their estates to their heirs. Both objectives can be accomplished through the proper estate tax planning techniques and strategies that are available today. If you are nearing retirement and have appreciated investments, you should examine this technique. Be sure to consult your tax advisers, accountant and/or attorney for additional information concerning this article because individual situations differ. Your advisers can help you decide the appropriate strategy for your own specific situation. □

*The author welcomes readers' questions. He can be reached at 1-800-262-3863.*

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# Physician founds clinic for resort's needy

Tina Sims  
Managing Editor

Jack McConnell, M.D., moved to Hilton Head, S.C., six years ago. He and his wife were going to enjoy life as retirees in the coastal paradise. They looked forward to sampling the city's cultural and recreational offerings and trying a new restaurant every day.

But Dr. McConnell, who had retired as a researcher with Johnson & Johnson in New Brunswick, N.J., began to notice that not everyone in the resort city was living the easy life. He occasionally picked up hitchhikers. Being naturally curious about their medical care, he would ask them where they went when they were sick. Almost always, they replied

that they didn't go anywhere. A trip to the nearest clinic meant a whole day off work. If they sought care at the hospital emergency department, they said they were not treated well. As a result, they often tried to cure their illnesses with herbal remedies.

The lack of medical care for the city's poor and needy – who made up one-third of the population – bothered Dr. McConnell. He knew he had to try to improve their situation.

His efforts paid off. A free clinic, the Volunteers in Medicine clinic, opened in July 1994 in Hilton Head. "Every person who lives in our town has easy access to medical care," says Dr. McConnell. "No one pays a dime."

Speaking at the Health Care for the Homeless and Poor Confer-

ence held recently in Indianapolis, Dr. McConnell explained how he established the clinic.

Dr. McConnell worked diligently to recruit physician volunteers for the clinic, but the physicians – most of them retired – wanted two assurances: that the life savings would not be at risk for medical liability and that those who had moved to Hilton Head from other states would be exempt from the South Carolina medical license fees and exam.

The State Board of Medical Examiners heard Dr. McConnell's request for a waiver of the license fee and exemption from the exam for physicians who provide free care, but was not sympathetic. It denied his petition.

Dr. McConnell refused to give up. He persuaded a physician who was a member of the state legislature to attach the provision to a bill "that nobody would notice," says Dr. McConnell.

The bill passed, and although the board of medical examiners "still did not like the idea," it complied with the changes. "It's difficult to change a culture around," Dr. McConnell explains.

Individual physicians who donate their services at the clinic are protected against malpractice as a result of their designation as non-paid employees, or "professional volunteers," of the clinic. The clinic is able to buy malpractice insurance for the professional and lay volunteers for a total of \$2,500 per year.

Opening the clinic required not only recruiting staff but raising funds for the building, which was built on city property and leased for \$1 per year for 30 years. The



Jack McConnell, M.D., left, founder of the Volunteers in Medicine clinic in Hilton Head, S.C., talks with James Trippi, M.D., an Indianapolis cardiologist and founder and president of the Gennesaret Free Clinic in Indianapolis. Dr. Trippi helped organize the Healthcare for the Homeless and Poor Conference, which featured an address by Dr. McConnell.



staff includes 24 physicians, 46 nurses and 14 dentists.

"It's one of the most joy filled places on the island," Dr. McConnell says of the clinic. Each patient is greeted warmly and courteously and accompanied by an "escort" during the office visit. The escorts not only make the patients feel comfortable and show them around but also serve as concerned listeners. Escorts always ask the patients, "How are things going in your life?" and show a sincere interest in their answers, says Dr. McConnell.

"Two human beings locked in a moment of sharing and caring" is how Dr. McConnell describes such a scene. "You can't tell who's the caregiver and who's the patient."

He thinks all patients deserve such consideration. For too long, medicine has taken the approach of "treat the disease but not the person," he says.

The clinic makes it easy for people to get the care they need. A church group offers free transportation. Free child care is available for patients during their visit. Pharmaceutical companies donate 95% of the drugs.

Numbers help tell the story of the clinic's success. The clinic saw 5,310 patients its first year, but at the current rate of visits expects that number to jump to 8,000 for the second year.

Dr. McConnell, now chairman emeritus of the clinic, offers the following advice for those considering starting a clinic in their city: You'll need more money than you think you will, and you'll run out of space before you think you will.

And those restaurants he wanted to try? Apparently he's found something much more satisfying to do with his time. □

## New law aids needy and doctors

Thanks to a new Indiana law, retired physicians can now volunteer their care of the poor without the burden of paying for malpractice premiums themselves. Senate Bill 76, which was passed through the efforts of the Indiana State Medical Association, Sen. Marvin Riegsecker, the Gennesaret Free Clinic in Indianapolis and the Matthew 25 Center in Fort Wayne, allows state and local governments to purchase professional liability insurance for a clinic or health care facility that provides free health care.

During a press conference during the Healthcare for the Homeless and Poor Conference, Virginia A. Caine, M.D., director of the Marion County Health Department, pledged support for the retired physicians and dentists providing free care at Gennesaret through the county's purchase of malpractice insurance for those volunteers. The new law will benefit everyone involved. More indigent patients will receive care. Retired physicians who wish to serve the need will be able to do so since they won't have to pay the malpractice premiums themselves.

The new law also protects volunteer health care providers from civil liability while providing free care. □



Those attending the press conference on Senate Bill 76 included, from left, James Trippi, M.D., Gennesaret Clinic president, Indianapolis; Katherine Vaughn, Indiana State Medical Association; Louis Smith, M.D., Gennesaret volunteer, Indianapolis; Jack McConnell, M.D., Hilton Head, S.C.; and Virginia Caine, M.D., Indianapolis.

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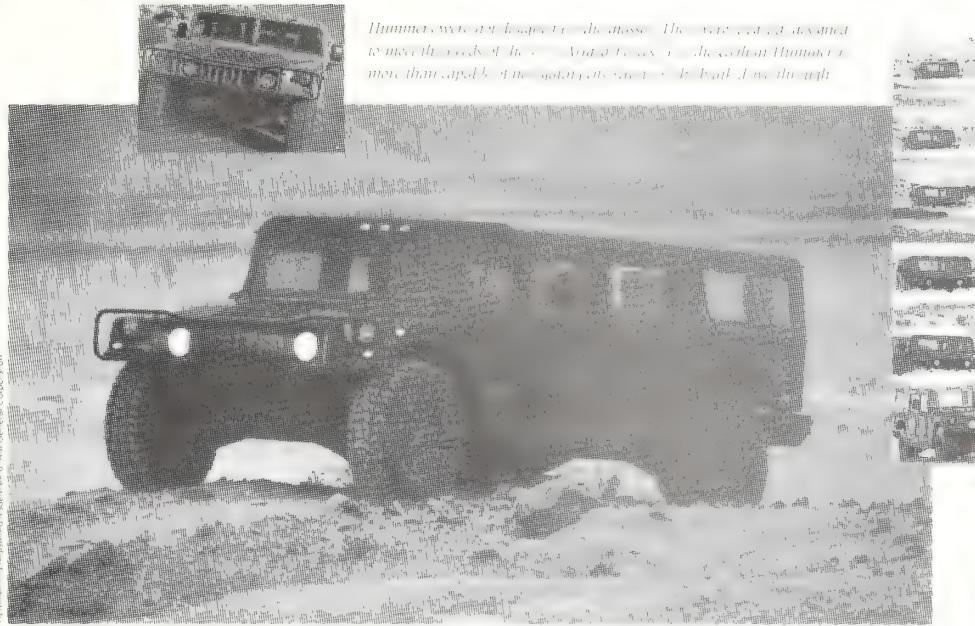
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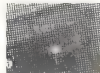


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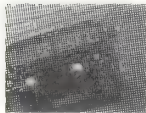
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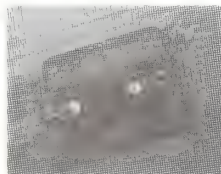
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# Treatment and outcome of minimal stage breast cancer in a local hospital setting

Rafat H. Ansari, M.D.  
Catherine A. Herrmann, ART,  
CTR

Memorial Regional Cancer Center (MRCC) of Memorial Hospital, South Bend, Ind., has noted an increase during the past 10 years in the number of breast cancer patients diagnosed with early stage disease. This parallels data reported by cancer centers across the United States and also has presented a dilemma regarding preferred therapy for such patients.

Many of these patients present with "minimal" breast cancer, defined as intraductal disease of comedo versus noncomedo type or infiltrating ductal carcinoma measuring 0.5 cm or less (AJCC-TNM stages T0 and T1a).<sup>1</sup> A review of literature published since 1990 shows a number of trials addressing the issue of primary treatment of early stage breast cancer, with treatment of choice varying between surgery as aggressive as modified radical mastectomy or as conservative as lumpectomy alone.<sup>1-10</sup>

The question of radiation therapy versus no radiation therapy is another debatable issue in management of some of these patients. Several studies have shown that high-grade intraductal tumors are associated with increased risk of recurrence within

the breast if treated with lumpectomy alone.<sup>10-16</sup> Most investigators now agree that these patients should be treated with either mastectomy or lumpectomy followed by radiation therapy. With so many options available for treatment of minimal stage breast cancer, we believe the primary therapy should be tailored for each patient.

In 1993, MRCC elected to review its treatment of minimal breast cancer for comparison with

published data. The study included newly diagnosed patients whose diagnosis met the definition of "minimal stage breast cancer" and who were accessioned into MRCC Cancer Registry from 1987 through 1992. Cases having mixed intraductal and invasive histologies were reviewed by pathologists to identify those with an invasive component larger than 0.5 cm, which were then eliminated from the study. Also eliminated were patients who met the definition of

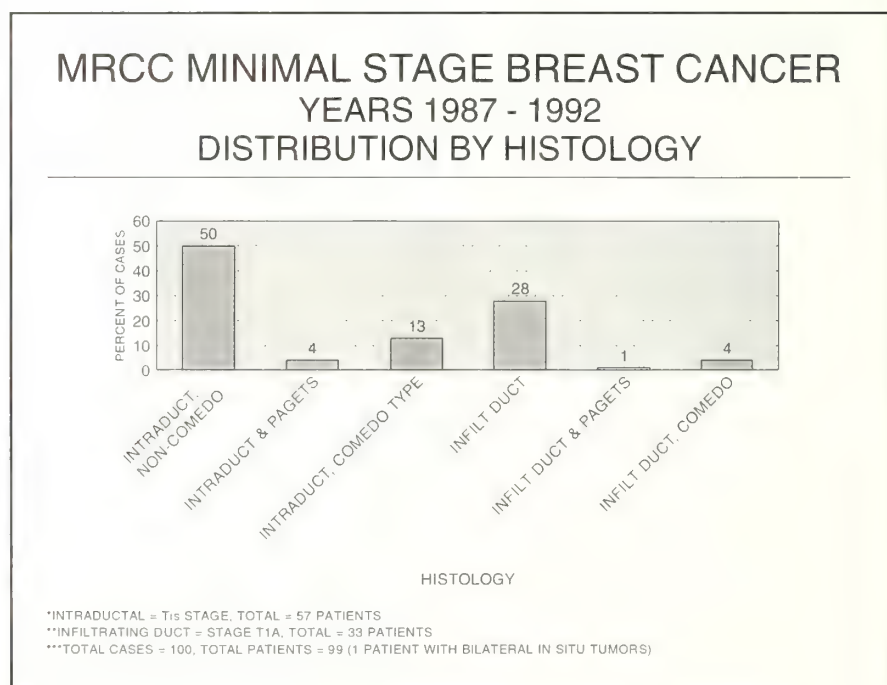


Figure 1



minimal breast cancer but who either had other primary cancers, multicentric disease, positive axillary nodes or a mixed intraductal and invasive tumor for which the size of the invasive component could not be determined.

Ninety-nine patients were identified as eligible for the study, totalling 100 breast tumors, with one patient having bilateral intraductal disease. Sixty-seven cases were in situ (intraductal), and 33 were Stage T1a, with 25 of the T1a also having an intraductal component (Figure 1).

Most cases were diagnosed on routine mammography, with only 18% having a palpable tumor. Figure 6 illustrates the percentage of tumors discovered by mammography versus palpation by patient age group.

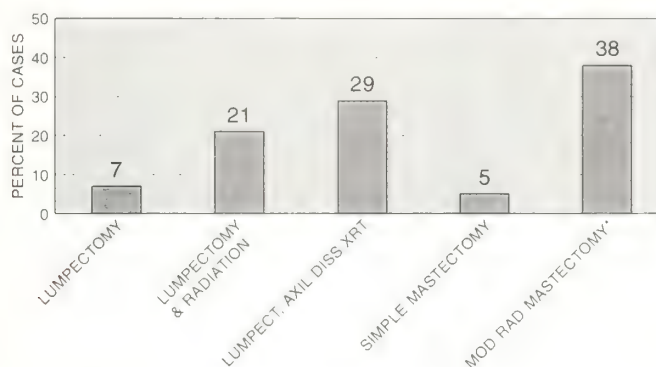
Fifty-seven patients (57%) were treated with conservative surgery, with or without axillary dissection and postoperative radiation therapy; five of these patients also received hormone therapy. Forty-three percent were treated with mastectomy; three patients in this group also received chemotherapy, and one was placed on hormone therapy (Figure 2).

A total of 82 patients (67 study patients and 15 additional patients with minimal stage lesions who were ineligible for reasons stated above) had axillary dissections. Of this total, only one patient had positive axillary lymph nodes.

As of September 1993, four patients are known to have recurrent or progressive disease following their initial treatment (Figure 3).

Five of the 99 patients are known to have died (Figures 4 and 5). Four died of unrelated causes, and one patient was classified in this study as "cause of death unknown." Her death certificate

## MRCC MINIMAL BREAST CANCER YEARS 1987 - 1992 TYPE OF SURGERY



\*ONE PATIENT ALSO TREATED WITH RADIATION

Figure 2

### MRCC MINIMAL STAGE BREAST CANCER YEARS 1987 - 1992 PATIENTS WITH RECURRENT/PERSISTENT DISEASE

Date Initial Diagnosis	Morphology	Original Treatment	Margin Status	Recurrent or Persistent Cancer	Subsequent Treatment	Last Contact and Cancer Status
April 1987	cribriform intraductal carcinoma	lumpectomy & radiation	not specified	regional recurrence 6/92	excision at regional site, Tamoxifen	4/93 disease free
September 1987	intraductal carcinoma	lumpectomy, axillary dissection & radiation.	suspect	in situ recurrence 1/91. Microcalcification on mammogram	mastectomy NOS	7/93 disease free
June 1992	moderately differentiated intraductal comedo-carcinoma	lumpectomy & axillary dissection	free	in situ-persistent 12/92. Calcification on mammogram	simple mastectomy with reconstruction	7/93 disease free
July 1987	intraductal carcinoma with comedo necrosis	lumpectomy & radiation.	not specified	in situ-persistent 6/88	modified radical mastectomy & axillary dissection	4/93 disease free

#### SUMMARY.

Two patients persistent disease. Both disease-free at last contact.  
Two patients recurrent disease. Both disease-free at last contact.

Figure 3

documented breast cancer as the cause of death, but a hospital record for cholecystectomy several months before her death showed no indication of recurrent cancer, nor did her records at the extended care facility where she resided before her death (Figures 4 and 5).

The median follow-up time for this study is 38 months, and the average time since last follow-up is three months. No patients are lost to follow-up.

### Conclusion

1. Ninety-five percent of the study patients are alive and disease-free at a median survival time of 38 months. No patients have died due to breast cancer. This compares favorably with published data.

2. Only one out of 82 minimal stage breast cancer patients who had an axillary sampling had positive lymph nodes (1.2%). Based on this relatively small number of cases, the probability of nodal involvement in limited stage breast cancer is approximately 1% to 2%. In the coming years, the role of routine axillary sampling in this group of patients could be challenged.

3. This study shows that the prognosis of these patients is very good, and the addition of systemic therapy adds no appreciable benefit. However, this study involved a relatively small patient population, and a longer follow-up period is needed to further assess this issue. MRCC will continue to monitor this group of patients through the cancer registry follow-up program to update patient survival. Long-term follow-up will also allow observation of the natural behavior of this disease.

4. Approximately 15% of all patients diagnosed with breast cancer at MRCC have minimal stage breast cancer. Data from

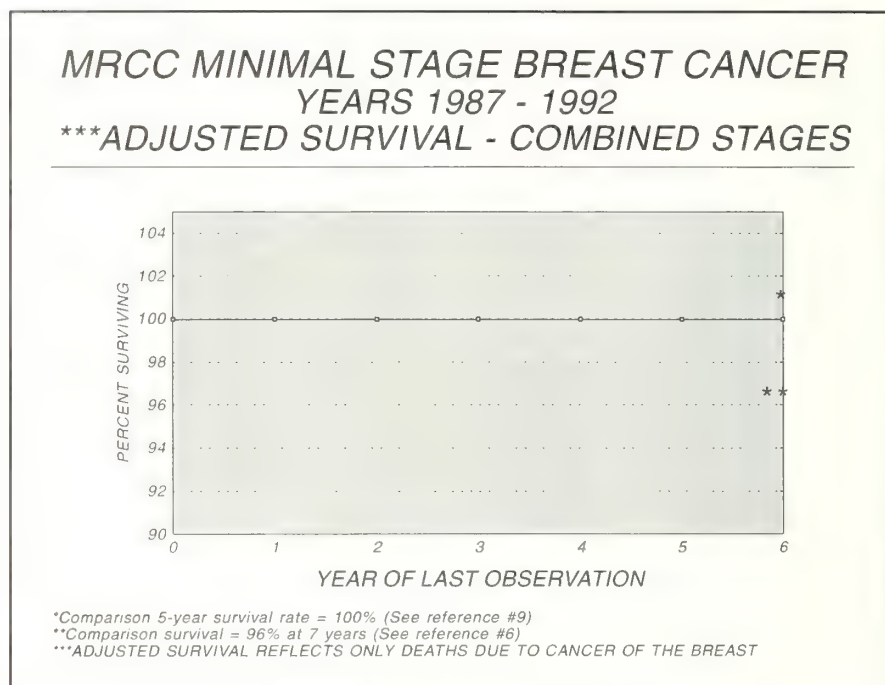


Figure 4

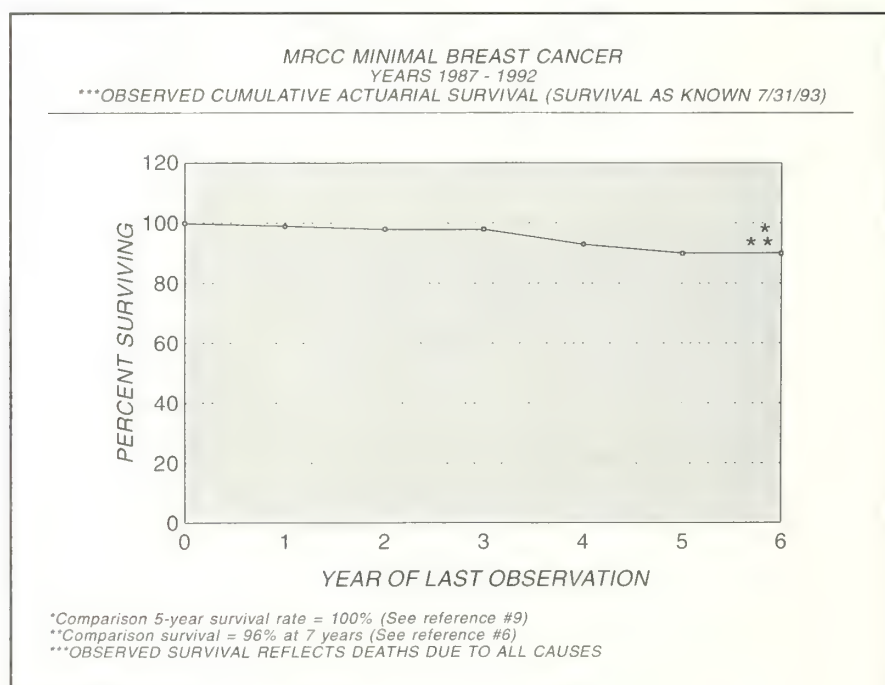


Figure 5

some institutions in the 1990s show that up to 20% to 25% of newly diagnosed cases are minimal stage. We hope our continued emphasis on breast cancer screening will result in early diagnosis and an increased percent of minimal stage breast carcinoma treated at MRCC.

5. Twenty-five percent of the patients in this study were ages 40 to 50, which supports our position favoring screening mammography in this age group. □

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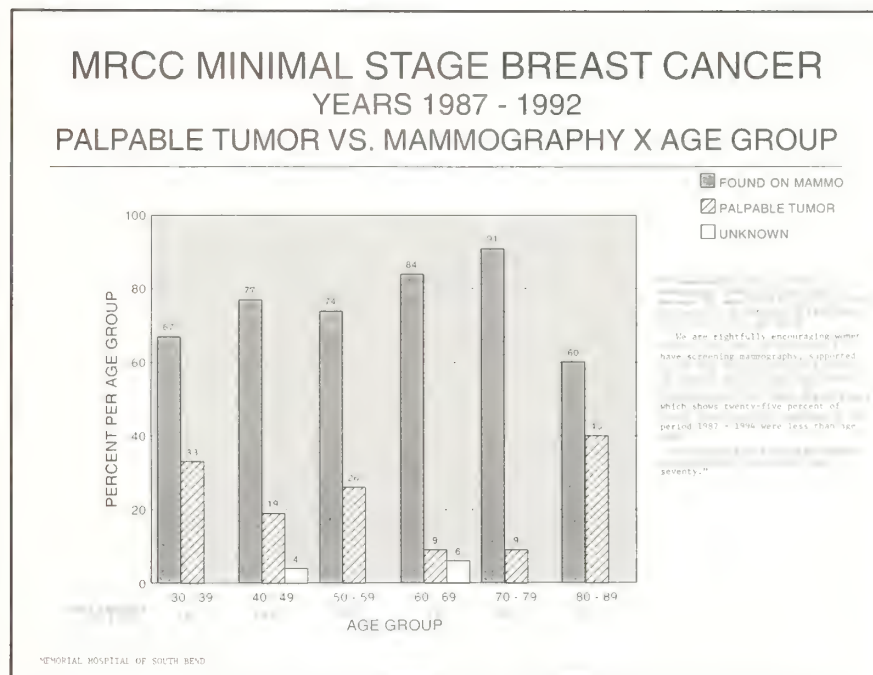


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# Teamwork improves breast cancer management in the community

George Friend, M.D.  
Rafat Ansari, M.D.  
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The multimodality approach to breast cancer treatment is well-established. During the late 1980s and early 1990s, it became increasingly apparent in our community that newly diagnosed breast cancer patients presented special challenges. Each case needed to be evaluated individually, with careful attention to mammographic and microscopic findings. The evolution of new diagnostic and therapeutic modalities is steadily challenging established approaches. The emotional anxiety of many newly diagnosed cancer patients and families is high.

Weekly breast cancer conferences are well-established at many university hospitals. Our community is served by two community hospitals and receives referrals from a wide area in northern Indiana and southern Michigan. Approximately 250 new cases of breast cancer are treated in South Bend yearly. In 1992, a weekly breast cancer conference was started as a trial in our community. Newly diagnosed breast cancer cases as well as cases with follow-up and later management issues were presented and discussed. The value was immediately apparent,

and the weekly meeting is now well established. The following is a description of the format and unexpected benefits.

The conference is held from 7 a.m. to 8 a.m. on the first four Thursdays of the month, alternating between the two hospitals. Approximately four cases are discussed each week. New cases can usually be presented the week following biopsy or surgery. A traditional format is used for case presentation: a brief history by the physician who scheduled the case; review of mammograms, x-rays and scans, review of the pathology slides (projected) and discussion. Almost all patients have had some surgical procedure of the breast, and the tissue diagnosis is already established.

The conference is attended regularly by primary care physicians and general surgeons, medical oncologists, radiation oncologists, pathologists, radiologists and plastic surgeons. In addition, medical students and a large number of hospital staff attend, including oncology and surgical nurses, mammography and radiotherapy technologists, social workers and cancer registrars.

Most newly diagnosed cases in the community are presented, and most of them have special features for discussion. General surgeons or medical oncologists usually

present the cases, but many have come through radiation oncology, referred from around the region. Informal notes that are not part of the patient's permanent medical record are kept.

## Results

Projecting the mammograms and microscopic slides shed light on the scope of each case. Information was clarified that often was not completely clear in a written report. Issues regarding extent and aggressiveness of disease, margins, surgical options, radiation therapy, hormonal and/or adjuvant chemotherapy, indications and socioeconomic issues are openly discussed and debated. Frequently, there is consensus of opinion; often there is not. Always, issues are clarified and information is exchanged.

The conference has proven invaluable in other ways, not entirely expected:

1. It has significantly improved the working relationships between various specialties, which has translated to expediting the patient through "the system" with more of a teamwork approach.

2. The conference has been an ongoing source of continuing education for the physicians and the staffs. Each case is a learning experience. All physicians in the various specialties have developed a more in-depth ability to care for breast cancer patients.

3. Guidelines for management have evolved and are continuously being refined and revised. For example, the conference addressed the need and use of stereotactic equipment and formulated community guidelines for long-term follow-up of breast cancer patients.

4. The conference has become a pivotal part of the management of patients. Often decisions are deferred until the case can be discussed at the conference.

5. Occasionally a patient and spouse have attended the discussion. This is usually done when a particularly well-informed patient wants to hear "all sides," and the attending physician believes she will benefit from that visit. In each case this has been of real benefit to the patient in her decision-making process.

6. Another pleasant surprise has been the consistency of high attendance and the active participation of all attendees. This is certainly attributable to the high

interest in breast cancer and, possibly for some, continuing medical education credit of one hour. We believe most attend because of the high value of the conference to the patient, physician and staff.

#### Summary

The weekly breast cancer conference has clearly improved this community's ability to care for breast cancer patients. The range of issues has been broad. Some of the discussions are related to various aspects of surgical care, pathology issues such as specimen marking and evaluation, the use of prognostic indicators, adjuvant treatment, hormone replacement, bone marrow transplantation, post lumpectomy mammography, etc. The list is endless and expands every week.

This conference format is very feasible in a community setting and has ongoing in-depth benefits. Each host hospital designates one

person to regularly coordinate preparation of the host hospital's conference. This ensures timely retrieval of all related diagnostic information for review by the radiologist and pathologist. Additionally, the case history is typed and available only on the morning of the conference. □

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---

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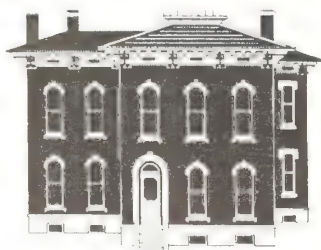
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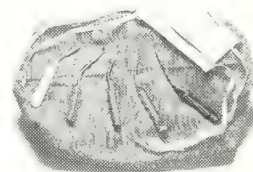


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# ■ alliance report

Valerie Gates  
ISMA Alliance president

The ISMA Alliance annual convention was held in conjunction with the ISMA convention in October.

The focus for the coming year will be two-fold. There will be an continuation of the ongoing efforts of our state and county organizations to address family violence and abuse issues as well as an emphasis on the medical family and its survival.

Our first workshop was a two-hour program held Friday, Oct. 20, during the convention. Clifford Kuhn, M.D., also known as the "Laugh Doctor," presented a program on healing and the shock of sudden changes. Dr. Kuhn also spoke at the Friday evening dinner held in honor of Ann Wrenn, newly elected Indiana alliance member to the AMA Alliance Executive Committee. Sharon Scott, AMA-A president, attended the ISMA-A convention and assisted with leadership training on Thursday for the Board meeting and spoke at Friday lunch on the medical family.

## 1995-1996 Executive Board

Valerie Gates, president, Porter County  
Patty Lackey, president-elect, Vanderburgh County  
Cheryl Haslitt, first vice-president, Delaware/Blackford County  
Fran Foster, northern area vice-president, Allen County  
Donna Dersch, central area vice-president, Delaware/Blackford County  
Laurel Weddle, southern area vice-

ISMA Alliance calendar	
<b>1995</b>	
Nov. 15 .....	Committee meetings at ISMA
<b>1996</b>	
Jan. 16 .....	Medicine Day with Board meeting and Workshop
Feb. 3-6 .....	Confluence II in Chicago
Feb. 15 .....	Nominating committee meeting at ISMA
March .....	Alliance Month
March 7 .....	Committee meetings at ISMA
March 15 .....	Dues deadline
March 30 .....	Doctor's Day
April 30 .....	Committee meetings at ISMA
May .....	AMA-ERF totals due to AMA-A
May 1 .....	Board meeting and Adolescent Health Workshop
May/June .....	Regional leadership training workshops
June 23-25 .....	AMA-A convention in Chicago
July .....	Counties review membership lists for state
Aug. 15 .....	Resolutions for convention due to ISMA-A
Aug. 29 .....	Committee meetings at ISMA
Sept. 30 .....	Annual reports from counties and officers due
Oct. 13-15 .....	Confluence I in Chicago
Oct. 17-19 .....	ISMA-A Convention at Westin Hotel, Indianapolis

president, Bartholomew /  
Brown County  
Phyllis Walker, secretary, Monroe /  
Owen County  
Sharon Gilmor, treasurer, Indiana-  
napolis  
Pat Walker, finance secretary, Vigo  
County  
Sue Ellen Greenlee, past president

## 1995-1996 county presidents

### Central area:

Delaware/Blackford, Janice  
Leiphart  
Indianapolis/Marion, Anita  
Johnson  
Wayne/Union, Margaret Grayson

### Southern area:

Bartholomew/Brown, Sandy Fox  
Clark, Aggie Matibag  
Dubois, Janice Kemker

Floyd, Ann Garner  
Knox, Denise Hendrix  
Madison, Lynn Brazel  
Monroe/Owen, Leigh Richey  
Tippecanoe, Susan Bitar  
Vanderburgh, Sylvia Dulay  
Vigo, Mary Lou Tenbrink

### Northern area:

Allen/Fort Wayne, Helen Nill  
Elkhart, Judith Van Curen  
Grant, Vangie Gunter  
Howard, Myla Jean Stuart  
Lake, Karen Brown  
LaPorte/LaPorte, Donna Serna  
LaPorte/Michigan City, Jeannie  
Houck  
Noble/LaGrange, Carol Chandler  
Porter, Kim Beiser  
St. Joseph, Joan Wehlage and  
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## ■ from the museum

### Museum to open exhibit on history of radiology

Oren S. Cooley  
Indianapolis

German physics professor Wilhelm Conrad Roentgen (1845-1923) discovered x-rays Nov. 8, 1895, in Wurzburg, Germany, while conducting laboratory experiments on the nature of light.

Roentgen's experiments included tests in which he passed electrical charges through electrodes in sealed glass tubes from which most of the air had been removed. Physicists at the time called the fluorescing rays that resulted from such experiments "cathode rays," known today as electrons. These tests, similar to other experiments then being conducted by physicists internationally, were designed to determine whether light consisted of waves or particles.

Roentgen was trying to detect the presence of cathode rays outside these glass tubes during his experiments Nov. 8, 1895. To see these rays more distinctly, he covered a tube with light-proof paper and then darkened the room as he passed an electrical charge through the tube. During this experiment, Roentgen detected that a small, barium platinocyanide screen across the laboratory from the tube had started to glow.

Roentgen concluded that the cathode rays could not have caused this glow, since scientists already had shown that these rays could not travel that far. Suspecting the presence of another kind of ray, he repeated the experiment several times, each time moving the screen farther away from the

tube.

Since the screen glowed during these subsequent tests, Roentgen attempted to produce a shadow on the screen by placing his hand in front of the screen. As a result, he saw the bones and outline of his hand.

During subsequent experiments, Roentgen quickly discovered that these new rays would penetrate not only paper and wood but other substances, including some metals. He also exposed photographic plates to these new rays, selecting as his subject his wife's hand. The resulting image clearly depicted her bones and wedding ring, through which the rays could not pass.

The new rays Roentgen had observed resulted from activity between the two electrodes within the partially evacuated glass tube. Named after British scientist Sir William Crookes (1832-1919), the Crookes tube contained a negative electrode, called a cathode, and a positive electrode, called an anode.

When Roentgen applied electric current between the cathode and anode, the residual gases inside the tube became ionized and, consequently, broke apart into positive and negative charges. As the positive ions in the gases bombarded the negative electrode, electrons (referred to as "cathode rays" by physicists at that time) were released and, consequently, bombarded the anode, which in turn produced the x-rays.

Although the first person to observe x-rays, Roentgen was not the first physicist to produce x-

rays. As early as 1890, Arthur W. Goodspeed (1860-1943), a professor of physics at the University of Pennsylvania, actually exposed photographic plates to x-rays. Puzzled over the fuzzy images that appeared, Goodspeed did not know the images' significance until Roentgen discovered x-rays five years later.

Roentgen conducted the first public demonstration of these new rays at a meeting of the Wurzburg Physical Medical Society on Jan. 23, 1896. Although Roentgen suggested that the term "x-ray" should serve as a designation for this discovery, Swiss anatomist Albert von Kolliker (1817-1905) suggested that these new rays should have the name "Roentgen rays," a recommendation enthusiastically supported by the entire audience.

The Indiana Medical History Museum will open a new exhibit on the history of radiology in November. The museum, located at 3045 W. Vermont St., Indianapolis, is open from 10 a.m. to 4 p.m., Wednesday through Saturday. For more information, call the Indiana Medical History Museum at (317) 635-7329. □

Sources: *Radiology: An Illustrated History* (1992) by Ronald L. Eisenberg, M.D.; *Wilhelm Conrad Roentgen and the Early History of the Roentgen Rays* (1934) by Otto Glasser.

*The author is director of the Indiana Medical History Museum in Indianapolis.*

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Tina Sims, Managing Editor  
Date  
Sept 29, 1995

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# ■ cme calendar

## Indiana University

The Indiana University School of Medicine will present the following CME courses:

- Nov. 17** - American Academy of Physicians Indiana Scientific Meeting, Hyatt Regency, Indianapolis.
- Nov. 17** - Diagnosis and Management of Patients with Bipolar Disorder, University Place Conference Center and Hotel, Indianapolis.
- Nov. 29** - Treating Common Conditions of the Upper Extremity, University Hospital, Indianapolis.
- Dec. 1** - Osteoporosis for Rheumatologists, University Place Conference Center and Hotel, Indianapolis.
- Feb. 16** - Violence, University Place Conference Center and Hotel, Indianapolis.
- Feb. 24-25** - Indiana Society of Anesthesiologists, University Place Conference Center and Hotel, Indianapolis.

For more information, call (317) 274-8353.

## Rush University

Rush-Presbyterian-St. Luke's Medical Center will present "Neurology for the Non-Neurologist"

Dec. 6 through 8 at the Swissotel in Chicago.

For additional information, call (312) 942-7095.

## St. Vincent Hospitals

St. Vincent Hospital and Health Services in Indianapolis will present these CME courses:

- Dec. 1** - 13th Annual Update in Cardiology, Westin Hotel, Indianapolis.
- Mar. 15** - Emergency Room Physicians Seminar, location to be announced, Indianapolis.
- Apr. 27-28** - 14th Annual Spring Seminar in Dermatopathology - "Compare Your Diagnoses with Bernie's," St. Vincent Hospital Cooling Auditorium, Indianapolis.
- May 10** - Progress in Cardiology IX, Westin Hotel, Indianapolis.

For more information, call Beth Hartauer, (317) 338-3460.

## Washington University

Washington University School of Medicine will present these CME courses:

- Dec. 1** - Women's Healthcare Issues.
- Dec. 9** - Contemporary Management of Myocardial Infarction.
- Mar. 13-15** - Annual Refresher Course and Update in General Surgery.

**Mar. 21-22** - Clinical Pulmonary Update.

**Mar. 30** - Cardiopulmonary Bypass & Coagulation Deficiencies for Surgeons.

All courses will be held at the Washington University Medical Center in St. Louis. For more information, call 1-800-325-9862.

## University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Feb. 25** - Radiology in the Mountains, Snowmass, Colo.
- Mar. 1** - Radiology in the Desert - Practical Aspects of Radiology and Imaging, Marriott's Camelback Inn Resort, Golf Club & Spa, Scottsdale, Ariz.
- Mar. 10-14** - Radiology in the Desert - Practical Aspects of Radiology and Imaging, Marriott's Camelback Inn Resort, Golf Club & Spa, Scottsdale, Ariz.

To register, call Vivian Woods at (313) 763-1400.

## CEREC Center

CEREC Center of Southeast Florida, an independent program for the advancement of Clinical Ethics Research, Education and Consultation, will present "Ethical Issues in the Care of Terminally Ill and Dying Patients" Dec. 15 through 18 at the Rolling Hills Hotel & Golf Resort in Fort Lauderdale, Fla.

To register, call Dr. Jos V.M. Welie at (305) 424-9304. □



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## ■ news briefs

### **IU gets grant for gene therapy vector lab**

The Indiana University School of Medicine was selected as a site for one of only three national laboratories for the production of gene therapy "vectors" funded by the National Institutes of Health (NIH). Funding for the first year of the five-year grant is \$860,000.

Viral vectors and other agents are the focus of basic science research to transfer new genetic information into human cells to treat or cure disorders. The NIH-funded laboratories will create the supplies of vectors necessary to meet increasing national demands for these products and ensure – through FDA oversight – quality and cost-effective production of the products. IU will become the site for retroviral and adeno-associated vector production.

The vector production laboratory will be located in the new cancer research building under construction on the medical center campus in Indianapolis. Kenneth Cornetta, M.D., is principal investigator of the vector laboratory.

### **Statewide specialty network announces name change**

Indiana's largest specialty physician network has changed its name from Specialty Physician Alliance Network to Specialty Physician Access Network (SPAN). The name was changed to more accurately reflect the mission of the venture, which is to provide access to quality specialty services throughout the state.

SPAN was developed to offer insurance companies, employers, managed care companies and health plans a single point of access to the specialists it represents. It was established as the

result of interest by two orthopaedic groups, The Indiana Hand Center and Orthopaedics Indianapolis.

SPAN now has 16 orthopaedic participating practices in 65 locations throughout the state. The latest additions to the network are Capitol Orthopaedics and Melanie Sanders, M.D., in Indianapolis and the South Bend Orthopaedic Surgery and Sports Medicine Clinic.

SPAN offices are located at 10293 N. Meridian St., Suite 175, Indianapolis, IN 46290, (317) 816-7726 or 1-800-575-7726.

### **COLA offers free information by fax**

Brief but comprehensive information on commonly asked office laboratory questions and the CLIA '88 regulations is now just a fax away.

The Commission on Office Laboratory Accreditation (COLA), in cooperation with the Centers for Disease Control and Prevention (CDC), is offering the service. Physicians and their staffs can call COLA customer service toll-free at 1-800-298-8044 to request the information. CLIA fact sheets will be faxed the same day to physicians or laboratories requesting the information.

The single-topic fact sheets condense information from a variety of sources, such as the *Federal Register* and laboratory manuals, into a user-friendly, one- and two-page format. The 33 fact sheets cover such topics as quality assurance, quality control, proficiency testing, OSHA, personnel standards, CLIA and other laboratory requirements.

For more information, call COLA at 1-800-298-8044.

### **Hospital and health care mergers, affiliations**

This list briefly summarizes recent news of mergers, acquisitions and affiliations of hospitals and other medical institutions. The information is reprinted from *Indiana Economic Log* with permission of NBD Bank, which compiles the list from newspaper stories.

- Arnett Clinic in Lafayette has agreed to affiliate with the publicly traded PhyCor Inc. – The Physicians Corp., based in Tennessee. Arnett physicians will remain a part of their own professional association, non-physician staff will become PhyCor employees, and the clinic's assets will belong to PhyCor, but its name will not change. Arnett has acquired primary care practices in Delphi, Flora, Otterbein, Rossville and Wolcott. The affiliation will provide capital for additional acquisitions.
- Hospitals in Columbia City, Huntington and Wabash have joined in an affiliation with Parkview Memorial Hospital in Fort Wayne. The affiliation will be called Parkview Health System. The smaller hospitals will concentrate on basic medical services, while Parkview will provide basic services for Allen County residents and more specialized and intensive care for patients from around the region. The hospitals will remain independent.
- Methodist Hospital in Indianapolis has taken control of Bedford Regional Center, following the approval by directors of an agreement between the two. The arrangement is called "parent-like," not a merger, and Bedford will



remain a separate, nonprofit corporation. Bedford is a 117-bed facility with 650 employees and a satellite clinic in Bloomington.

- Nasser, Smith & Pinkerton Cardiology of Indianapolis has affiliated with Ohio Valley HeartCare Inc. of Evansville and The Heart Center of Fort Wayne to create Gateway LLC Medical Resource Alliance. Gateway has 64 cardiologists and 23 primary care doctors providing services in Indiana, Kentucky, Illinois and Ohio.
- Elkhart General Hospital has joined Michiana CompNet, a workers' compensation preferred provider organization (PPO). The PPO also includes Memorial Hospital of South Bend, the Center for Occupational Health, Med-Point, Memorial Home Care, durable medical equipment services and pharmacies. □

### ISMA members offered Citizens home, auto insurance

**T**hrough a special program with Citizens Insurance, members of the Indiana State Medical Association are eligible for complete insurance coverage for their homes and automobiles at reduced rates.

Members can receive a 5% discount from Citizens' standard rates for auto insurance and a 10% discount from the company's standard rate for homeowners or rental insurance.

Agency Associates Inc. in Zionsville is the administering agency, but ISMA members can apply for Citizens Insurance with any of the company's 160 independent agency locations throughout the state.

Although the program is available to all ISMA members, it is not a true group plan. Applicants will be individually underwritten.

Last fall Citizens introduced franchise programs, a new approach to marketing personal lines insurance in Indiana, offering special discounts to members of qualifying professional organizations and associations. The insurer worked with the ISMA to create a franchise program for its members. The program was reviewed and approved by the ISMA board of trustees.

"The intent of franchise programs is to reward better-than-average risks within a desirable class of business," said William Schramm, vice president and general manager of Citizens Indiana operations. "Favorable experience within a franchise program will result in experience credits, which are passed on as premium discounts for the individuals within the program."

ISMA members will receive a detailed brochure on the program. □

## ■ drug names

**Benjamin Teplitsky, R. Ph.**  
Brooklyn, N.Y.

### Look-alike and sound-alike drug names

	<b>PENETREX</b>	<b>PENTRAX</b>
<b>Category:</b>	Antibiotic	Antiseborrheic
<b>Brand name:</b>	Penetrex, Warner-Lambert	Pentrax, GenDerm
<b>Generic name:</b>	enoxacin	(tar derivative)
<b>Dosage forms:</b>	Tablets	Shampoo
	<b>PERCOCET</b>	<b>PERCODAN</b>
<b>Category:</b>	Narcotic analgesic	Narcotic analgesic
<b>Brand name:</b>	Percocet, DuPont	Percodan, DuPont
<b>Generic name:</b>	(oxycodone HCl - acetaminophen comb.)	(oxycodone HCl - aspirin combination)
<b>Dosage forms:</b>	Tablets	Tablets

**L**ook-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □



## ■ obituaries

### **Julia L. Adams, M.D.**

Dr. Adams, 85, retired director of the Amelia T. Wood University Health Care Center at Ball State University, died Sept. 2, 1995, in Ball Memorial Hospital in Muncie.

She was a 1933 graduate of the Washington University School of Medicine in St. Louis.

Dr. Adams opened a practice in Muncie in 1942. She joined the medical staff at the Ball State health care center in 1946 and retired as acting director in 1976. She came out of retirement in 1980 to serve as director until June 1981. Dr. Adams was active in the community, contributing service to the Child Guidance Clinic, Alpha Center, Planned Parenthood of East Central Indiana and Aid to Community Service.

### **John W. Armstead, M.D.**

Dr. Armstead, 66, a retired Indianapolis obstetrician/gynecologist, died July 19, 1995.

He was a 1953 graduate of the Howard University College of Medicine. He was an Army veteran and served in the Army Reserve, retiring with the rank of colonel.

Dr. Armstead was in private practice from 1960 to 1992.

### **Charles E. Austin, M.D.**

Dr. Austin, 76, a retired Anderson general practitioner, died July 13, 1995.

He was a 1949 graduate of the Indiana University School of Medicine and served in the Medical Corps during the Korean War.

Dr. Austin had a private practice in Anderson 40 years. He had been president of the medical staff at Community Hospital in Anderson and served as the

Anderson health officer several years.

### **Norman E. Beaver, M.D.**

Dr. Beaver, 75, a family physician in Berne for 28 years, died July 4, 1995, at Parkview Hospital in Fort Wayne.

He was a 1944 graduate of the Indiana University School of Medicine and served as a captain in the Army Medical Corps.

Dr. Beaver was a staff member of the Purdue University Health Service for 10 years and was also on the staff at Home and St. Elizabeth hospitals. He was Adams County health officer for many years. Dr. Beaver served on the Berne Area Development Committee and the South Adams School Board.

### **Frank H. Coble, M.D.**

Dr. Coble, 85, a retired Richmond ophthalmologist, died Aug. 23, 1995, in New Smyrna Beach, Fla.

He was a 1934 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

After several years as a general practitioner, Dr. Coble took postgraduate training and then specialized in ophthalmology until his retirement in 1984. He was a member of the American Academy of Ophthalmology. A former president of the National Flying Physicians Association, he implemented the group's disaster relief plan, which was a nationwide effort by 2,000 physician pilots who volunteered their planes and medical services when needed.

### **Lee N. Foster, M.D.**

Dr. Foster, 79, the former medical director of St. Vincent Hospital School of Medical Technology in

Indianapolis, died July 12, 1995, at his home in Carmel.

He was a 1943 graduate of the Northwestern University Medical School.

Dr. Foster was director of the medical technology school from 1952 to 1985 and was medical director of Cutter Biological Laboratories in Muncie from 1986 to 1987. He was named 1975-76 Teacher of the Year by the St. Vincent Hospital pathology staff. He was co-founder and the first president of Community Blood Bank of Marion County.

### **Thomas W. Hass, M.D.**

Dr. Hass, 69, a Lafayette obstetrician/gynecologist, died Aug. 23, 1995.

He was a 1949 graduate of the University of Illinois College of Medicine and a Navy veteran of World War II.

Dr. Hass, who had practiced in Lafayette since 1956, was on the staff of Home Hospital and St. Elizabeth Medical Center in Lafayette and was a member of the American College of Obstetricians and Gynecologists.

### **David S. Koransky, M.D.**

Dr. Koransky, 86, a retired Hammond ophthalmologist, died Aug. 2, 1995, at Community Hospital in Munster.

He was a 1934 graduate of the University of Illinois College of Medicine and a flight surgeon with the Air Force during World War II.

Dr. Koransky had served as chief of staff at the eye department at Hine's Veteran Hospital and was a clinical professor at Northwestern University Medical School.

## **Chester F. McClure, M.D.**

Dr. McClure, 75, a psychiatrist, died June 29, 1995, at King's Daughters' Hospital in Madison.

He was a 1965 graduate of the University of Louisville School of Medicine and served in the U.S. Army Air Corps.

Dr. McClure was on the staff at Madison State Hospital from 1993 to 1995. Previously he served eight years on the psychiatric staff at the prison in Michigan City and was in private practice in LaPorte and Michigan City. He also served as director of the psychiatric unit at LaPorte Hospital and director of the Swanson Center in LaPorte.

## **Dennis S. Megenhardt, M.D.**

Dr. Megenhardt, 90, a retired Indianapolis surgeon, died July 5, 1995.

He was a 1933 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Megenhardt served on the staffs at Wishard, Methodist, Community, St. Vincent and Winona hospitals in Indianapolis. He taught at the Indiana University School of Medicine, where he was named professor emeritus. He was named a Sagamore of the Wabash by Gov. Robert Orr. Dr. Megenhardt was a fellow of the American College of Surgeons.

## **William M. Mount, M.D.**

Dr. Mount, 83, a retired Lafayette allergist, died July 1, 1995, in Home Hospital in Lafayette.

He was a 1934 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Mount began his medical career in Crawfordsville in 1937 and moved to Lafayette in 1960. He was a member of the American Academy of Allergy and the American College of Allergists. He was a staff member emeritus at Home and St. Elizabeth hospitals in Lafayette.

## **Donal D. O'Sullivan, M.D.**

Dr. O'Sullivan, 66, an Evansville oncologist, died July 4, 1995, at St. Mary's Medical Center in Evansville.

He was a 1950 graduate of the Loyola University Stritch School of Medicine.

Dr. O'Sullivan had been on the staff at St. Joseph and Loretto hospitals in Chicago and Deaconess Hospital in Evansville. He retired in 1985 as a colonel in the Army.

## **Renu R. Pandya, M.D.**

Dr. Pandya, 39, a Lafayette psychiatrist, died June 7, 1995.

She was a 1979 graduate of the University of Bombay in Bombay, Maharashtra, India.

Before coming to Lafayette, Dr. Pandya had a private practice in Queens in New York City and was a clinical instructor at Columbia Presbyterian Hospital and Albert Einstein College of Medicine. She received a special award from the borough of Queens for her work

with the homeless. She moved to Lafayette in 1992 as attending psychiatrist and head of youth services at Charter Hospital.

## **Donald H. Rudser, M.D.**

Dr. Rudser, 86, a retired Whiting family physician, died Aug. 24, 1995, at home.

He was a 1936 graduate of Rush Medical College in Chicago.

Dr. Rudser was a member of the Lake County Medical Society and Plymouth Congregational Church.

## **Byron K. Rust, M.D.**

Dr. Rust, 91, a retired Indianapolis pediatrician, died Aug. 20, 1995. He was living in Sarasota, Fla., at the time of his death.

He was a 1927 graduate of the Indiana University School of Medicine and a Navy veteran of World War II.

Dr. Rust had served as chief of pediatrics at Wishard and St. Vincent hospitals. Under his direction, the American Board of Pediatrics approved pediatric residence training programs at both hospitals. After retiring, he served one year as a visiting professor of pediatrics at Jinnah Postgraduate Medical Center in Karachi, Pakistan. He was a past president of the Indiana State Pediatric Society and served as a special pediatric consultant for the National Head Start program for eight states. □



**D<sup>r.</sup> Mitchell Stucky**, a Fort Wayne family practitioner, was elected the first chairman of the Parkview Health System board of directors. The system is regionally based in northeast Indiana and responsible for overseeing the coordination of health care services among the system's partners, which include Huntington Memorial Hospital, Whitley County Memorial Hospital, regional physician practices and Parkview Hospital.



**Dr. Stucky**

**Dr. Larry Davis**, an Indianapolis psychiatrist, was named diplomate: board-certified forensic examiner of the American Board of Forensic Examiners.

**Dr. Douglas P. Zipes**, distinguished professor of medicine, pharmacology and toxicology at the Indiana University School of Medicine, was appointed director of the cardiology division and Krannert Institute of Cardiology at the IU Medical Center in Indianapolis.

**Dr. Donald A. Girod** of Indianapolis was named the first Carleton B. McCulloch Professor of Pediatrics at the Indiana University School of Medicine. Dr. Girod developed the pediatric cardiology program at Riley Hospital and the IU School of Medicine. McCulloch was one of the original incorporators of the Riley Memorial Association, which instituted and continues to fund Riley Hospital.

**Dr. Amy D. Konkle**, medical director of Northside Counseling and Psychiatric Center in Indianapolis, has received practitioner certification by the American

Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy.

**Dr. Stephen W. Perkins**, an Indianapolis facial plastic and reconstructive surgeon, presented a paper at the fall meeting of the American Academy of Facial Plastic and Reconstructive Surgery in New Orleans. He discussed the findings of his 10-year research of "Chin Augmentation with Mersilene Mesh."

Recent activities of physicians at Northside Cardiology in Indianapolis include the following: **Dr. Joe Noble** spoke on pharmacology of cardiology at the annual meeting of the Indiana Society of Cardiovascular and Pulmonary Rehabilitation in Indianapolis. **Dr. Eric N. Prystowsky** was an associate course director for the North American Society of Pacing and Electrophysiology board review course in cardiac electro-

### Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

#### July 1995

Brewer, David W., Evansville  
Gupta, Narendra, Logansport  
Pottanat, Jancy G., Washington  
Santos, Napoleon L., Highland  
Sawlan, Tulsi C., Valparaiso  
Schmidt, Jonathan L., Yorktown  
Widdifield, Garth E., Indianapolis  
Woodward, William M., Westville

#### August 1995

Bueter, Anne P., Carmel  
Crawford, John N., Fort Wayne  
Domingo, Moises B., Evansville

Fawver, Jay D., Fort Wayne  
Gentleman, James W., Crown Point  
Givens, Stanley S., Carmel  
Hall, Robert C., Carmel  
Hansell, Richard S., Indianapolis  
Hardin, Gregory T., Greenwood  
Isenberg, Steven F., Indianapolis  
Klutiny, George, Carmel  
Maurer, Sue, Fort Wayne  
Norins, Arthur L., Indianapolis  
Pauloski, Jeffrey C., Indianapolis  
Sandock, Mark S., South Bend  
Stein, Mark H., Indianapolis □

physiology in Chicago. **Dr. Mary Walsh** spoke about women and heart disease on the Kristiana television show on the 27 Alive cable station in Indianapolis.

**Dr. Thomas A. Felger** of Fort Wayne was elected president of the Indiana Academy of Family Physicians.

**Dr. Maurice Arregui**, an Indianapolis surgeon, spoke at the 50th anniversary of the Shouldice Hospital Symposium in Toronto, Canada; his topics were "Anatomy of the Groin as Seen Through the Laparoscope" and "Laparoscopic Herniorrhaphy." He also was guest co-editor for the proceedings of the meeting, which will be published as a two-volume issue titled *Problems in General Surgery*. Dr. Arregui spoke on "Update on Laparoscopic Hernia Repair in the United States" at a symposium at the University of Bern in Switzerland.



**Dr. Risk C. Sasso**, an Indianapolis orthopaedic surgeon, was a faculty member at the recent AO Advanced Spinal Techniques course in Los Cabos, Mexico. He lectured on anterior cervical plate fixation for fracture management and was a lab moderator for the anterior cervical instrumentation course.

**Dr. Richard E. Lindseth** of Indianapolis was appointed chairman of the department of orthopaedic surgery at the Indiana University School of Medicine.

**Dr. Steven F. Isenberg**, an Indianapolis otolaryngologist, received an American Academy of Otolaryngology Head and Neck Surgery Foundation Continuing Medical Education Achievement Award.

**Dr. Robert Hannemann**, a Lafayette pediatrician, was the editorial director of a new book titled *Caring for Your Baby and Young Child, Birth to Age 5: The Complete and Authoritative Guide*, published by the American Academy of Pediatrics. He is vice president of the AAP.

**Dr. Randall C. Morgan Jr.**, a Gary orthopaedic surgeon, is the new president-elect of the National Medical Association. He will be installed as president at the 1996 NMA convention in Chicago.

**Dr. George L. Compton**, a Tipton family practitioner, was selected as the grand marshal of the Tipton County Pork Festival Parade.

**Dr. Donald L. Snider**, a Vincennes surgeon, was elected president of the American Medical Flyfishing Association at its convention in West Yellowstone, Mont.

**Dr. Robert M. Seibel** has retired after 47 years as a family practitioner in Nashville, Ind. He

will continue as the county health officer.

**Dr. Marion Drake** has retired after 47 years in family practice in Elwood.

**Dr. James S. Robertson**, a Plymouth family practitioner, has retired.

**Dr. Louis Moosey** of Union Mills has retired after 57 years in family practice.

**Dr. Helen Barnes** of Greenwood has retired after 50 years as a pediatrician. She was the first female specialist in Johnson County.

**Dr. Gerald L. Miller**, a Markle family practitioner, was honored for his assistance to Alzheimer's disease patients and their families. He received a plaque, and the Alzheimer's wing at Markle Health Care was dedicated in his honor.

**Dr. Louis J. Calli**, a North Vernon family practitioner, was honored by the local AMVETS for his service to his country and the community.

#### ISMA new members

**Robert M. Baltera**, M.D., Indianapolis, orthopaedic surgery.

**Humberto A. Battistini**, M.D., Indianapolis, neurology.

**Frederick K. Beck**, M.D., Fishers, obstetrics and gynecology.

**Lisa D. Beihn**, M.D., Indianapolis, general surgery.

**Sailaja M. Blackmon**, M.D., Marion, obstetrics and gynecology.

**James W. Blatchford III**, M.D., Terre Haute, thoracic surgery.

**Michael G. Bonacum**, D.O., Corydon, internal medicine.

**R. Daniel Braun**, M.D., Indianapolis, obstetrics and gynecology.

**Valerie S. Bruemmer**, M.D., Indianapolis, internal medicine.

**J. Scott Buckley**, M.D., India-

napolis, gastroenterology.

**Frank M. Castillo**, M.D., South Bend, family practice.

**Robert J. Chloupek**, M.D., Terre Haute, general preventive medicine.

**Eve Grace Cieutat**, M.D., Terre Haute, thoracic surgery.

**David J. Foreit**, D.O., Hammond, family practice.

**Charles R. Harris**, M.D., Cicero, family practice.

**Henry C. Kim**, M.D., Indianapolis, anesthesiology.

**Hector O. Laurel**, M.D., New Albany, anesthesiology.

**Stephen D. Lugo**, M.D., Anderson, obstetrics and gynecology.

**Mohammed A. Majid**, M.D., Indianapolis, internal medicine.

**Tasmee Majid**, M.D., Indianapolis, pediatrics.

**Michael C. Malczewski**, M.D., Merrillville, plastic surgery.

**Michael S. Malian**, M.D., Indianapolis, general surgery.

**Michael E. McAndrew**, M.D., Lawrenceburg, general surgery.

**Mary E. McCormack**, D.O., Crown Point, obstetrics and gynecology.

**Gregory P. Moore**, M.D., Indianapolis, emergency medicine.

**Richard Payne**, M.D., Indianapolis, psychiatry.

**Kurt B. Repke**, M.D., Indianapolis, ophthalmology.

**Daniel B. Salvas**, M.D., Indianapolis, urological surgery.

**Ramesh C. Sharma**, M.D., Seymour, internal medicine.

**Deo Vrat Singh**, M.D., Indianapolis, internal medicine.

**Jeffrey S. Smith**, D.O., Marion, anesthesiology.

**Aneta Srbinoska**, M.D., Munster, internal medicine.

**Karl D. Stein**, M.D., Indianapolis, anesthesiology.

**Mark D. Totten**, M.D., Madi-

son, family practice.

**Jeffrey D. Vaught, M.D.,**  
Indianapolis, urological surgery.  
**Roderick L. Warren, M.D.,**

Evansville, neurology.

**Perry E. Wethington, M.D.,**  
Indianapolis, diagnostic radiology.  
**Brenda K. Woods, M.D.,**

Indianapolis, family practice.

**Basil A. Younis, M.D.,**  
Kokomo, internal medicine. □

## Physician mentors give insight into art of healing

**T**he ISMA would like to thank these Indiana physicians for volunteering their time to participate in the Physicians of Tomorrow Mentoring Program.

The physician mentors opened the door for approximately 60 Girl Scouts throughout the state and gave them the opportunity to see what a career in medicine would be like.

Annette Alpert, M.D., Bloomington, cardiology;  
Karen Amstutz, M.D., Indianapolis, pediatrics;  
Troy Bergin, M.D., South Bend, family practice;  
Mary Brunner, M.D., Zionsville, pediatrics;  
Elizabeth Burrows, M.D., Indianapolis, anesthesiology;  
Hope Chema, M.D., Indianapolis, family practice;  
Deborah Ciancone, M.D., Indianapolis, family practice;  
Judy Davis, D.O., Valparaiso, ophthalmology;  
Anne Eliades, M.D., Muncie, pediatrics;  
Holly Faust, M.D., Indianapolis, dermatology;  
Maria Fletcher, M.D., Brownsburg, pediatrics;  
Margaret Frazer, M.D., Indianapolis, neurology;  
Sheila Gamache, M.D., Indianapolis, cardiovascular diseases;  
Brenda Gierhart, M.D., Indianapolis, obstetrician/gynecologist;  
Irene Gordon, M.D., Lafayette, radiation oncology;  
Dianna Griggs, M.D., Martinsville, internal medicine;  
Harriet Hamer, M.D., South Bend, anesthesiology;  
Doris Hardacker, M.D., Carmel, anesthesiology;  
Eileen Hsu, M.D., Rochester, pediatrics;  
Debbie Hulbert, M.D., Indianapolis, pediatrics;  
Carol Johnson, M.D., Indianapolis, pediatrics;  
Monica Joyner, M.D., Indianapolis, plastic surgery;  
Aki Kawasaki, M.D., Indianapolis, neurology;  
Helen Kinsey, M.D., Columbus, obstetrics/gynecology;

Deanna Knoll, M.D., Plymouth, pediatrics;  
Diane Kolody, M.D., Franklin, family practice;  
Karen Kovalow-St. John, M.D., Michigan City, rheumatology;  
Donna Kozar, M.D., Evansville;  
Robin Ledyard, M.D., Shelbyville, family practice;  
Carol Lee, M.D., Columbus, gastroenterology;  
Madeline Lewis, D.O., South Bend, family practice;  
S. Chace Lottich, M.D., Indianapolis, general surgery;  
Elizabeth Mann, M.D., Richmond, pediatrics;  
Margaret Maxwell, M.D., Indianapolis, family practice;  
Cecilia May, M.D., Lafayette, internal medicine;  
Craig Moorman, M.D., Franklin, pediatrics;  
Nirmala Murugavel, M.D., Michigan City, internal medicine;  
Virginia Newman, M.D., Bloomington, cardiovascular surgery;  
Gwendolyn Niebler, D.O., Indianapolis, neurology;  
Shannon Oates, M.D., Lafayette, endocrinology;  
Elizabeth Pino, M.D., Indianapolis, pediatrics;  
Emily Pollard, M.D., Kokomo, plastic surgery;  
Barbara Siwy, M.D., Indianapolis, plastic surgery;  
Teresa Trierweiler, M.D., Indianapolis, family practice;  
Nicki Turner, M.D., Muncie, internal medicine;  
Mary Walsh, M.D., Indianapolis, cardiovascular diseases;  
Betty Lou Walsman, M.D., Indianapolis, neonatal-perinatal medicine;  
Lorraine Wean, M.D., Greenfield, pediatrics;  
Rosemary Weir, M.D., Seymour, family practice;  
Anna Welch, M.D., Lafayette, family practice;  
Rose Wenrich, M.D., Wabash, family practice;  
Karen Wheeler, M.D., Zionsville, pediatrics;  
Vickie Wipperman, M.D., South Bend, family practice;  
Theresa Woods, M.D., Lafayette, pediatrics; and  
Deborah Zygmunt, M.D., Evansville, internal medicine.

# Security Prescription Blanks

<b>Imprint Area 4 1/4 x 1</b>		<b>R</b> <b>X</b>
If logo desired Name & address area is 3 1/4 x 1		
Name _____		
Address _____	Date _____	
		<input type="checkbox"/> 1-24
		<input type="checkbox"/> 25-49
		<input type="checkbox"/> 50-74
		<input type="checkbox"/> 75-100
		<input type="checkbox"/> 101-150
		<input type="checkbox"/> 151 and over
Refill NR 1 2 3 4 5 Void after _____		
Dispense as Written _____ M D		May Substitute _____ M D
Prescription is void if more than one (1) prescription is written per blank		

## New security prescription law passed

A new rule passed in May by the Indiana Board of Pharmacy requires that security paper be used on all controlled substances as of Jan. 1, 1996. The rule was passed in an effort to prevent prescription forgeries and diversion.

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## classifieds

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**OFFICE FOR RENT:** 1,500-2,000 square feet, full- or part-time. Fully furnished. X-ray on premises. Ample, free parking. 1935 N. Capitol Ave., Indianapolis. Call (317) 923-4822.

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Immediate opening. Aurora in southeastern Indiana. Due to health reasons, Dr. Ivan T. Lindgren has decided to retire, effective Aug. 1, 1995. Dr. Lindgren has been practicing medicine since 1957 and started seeing patients at his current location 8/3/70. He is seeking someone to take over his family practice. Rural community/loyal patients. 1,000 patients. Fully experienced staff. Industrial accounts. Area doctor support. School athletics including sports physicals and pee-wee football. Office building includes x-ray machine, EKG, lab service, four patient examining rooms, executive office, reception area and computer system. Easy access to Cincinnati and Riverfront Stadium, symphony, performing arts, etc. Interested parties should call Loomis Lindgren, (517) 349-6180, home, or (517) 676-3000, work; Reid Hensley, (812) 926-0886, home, or (513) 681-2200, work; or Dr. Lindgren's office, (812) 926-2134.

**MEDICAL PRACTICE WITH ESTABLISHED OFFICE AVAILABLE** in Columbus, half-mile from Columbus Regional Hospital, junction of State Road 46 and U.S. 31. 30+ year-old medical practice left vacant by retirement of family practitioner. Only expense required to assume practice is rent, utilities and general office overhead. 1,200 square feet, fully furnished, low-maintenance office in professional complex. Exterior maintenance, snow removal included. Ideal opportunity for new physician. Contact Mrs. White, 2756 25th St., Suite 500, Columbus, IN 47203; fax (812) 372-0998; phone (812) 379-4494 days only.

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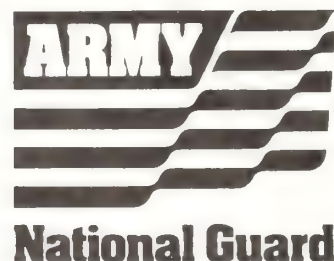
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## Coming in the January/February issue of Indiana Medicine

- How Indiana physicians are using the Internet and tips on how you too may find this a helpful tool in your practice.
- Photo highlights of the 1995 ISMA annual meeting.
- ISMA House of Delegates action on 1995 resolutions.
- The student paper that won the Frank B. Ramsey Medical Writing Award: "Sleeping Position and Sudden Infant Death Syndrome."

Watch for the issue  
in your mail after Jan. 10.

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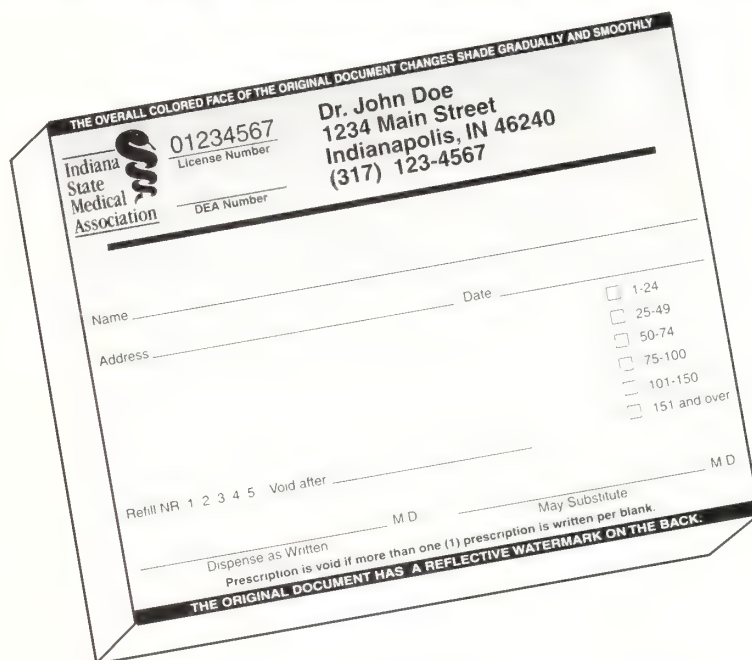
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